Bellimore Maryland 21215-0036

			riease	State of M			artment of H				_	bie.	
			1 - For State Registrar	State of W	iai yiai		rtificate of l			-	2.00	5	10001
			Decedent's Name (First, Middle, La	ist)					2. Da	te of Death			3. Time of Death
	Physici /Medic		Beulah M. Beav	ers					Z Z	onth	23-	Year O5	2:00 PM
7	Examin		4a. Facility Name (If not institution, given	e street and number	)		4b. City, Town, or	Location of	of Death		4c. County	of Death	
				Hospital C	ente	^	Roseo				Ba	1 timo	re
	Funeral		5. Social Security Number 6.5	Sex 7.A 1□M 2√2 F		last birthday, 77 Yrs.	Months Days	If Under Hours	Min. (M	te of Birth lonth, Day, Y		Coui	
	Director		235–38–0178 Usual Residence of Decedent			77 Yrs.			Sep	t.10,	1927	West	Virginia
	yland yland		10a. State 10b. County		10c. Cit	y, Town or L	ocation						10d. Inside City Limits
	e-fsl	ctor	Maryland Baltimo	re	Mic	ddle R	iver						1 ☐ Yes 2, ☐ No
	or 28	Director	10e. Street and Number				10f. Zip Code			100	g. Citizen of		ntry?
	s 23a		6922 University D	T		2 10	212		1000 7		U.S.A		
	Item Item	Funerai	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Decedent Armed Forces 1  Yes 2	?	.5. 13.	Was Decedent of Hi If Yes, specify Cuba	n, Mexican	gin? (Specify Yo n, Puerto Rican,	etc.)		ck, White,	etc.
936	urs af	ρ	3KQXWidowed 4 □ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 🏋 No	Specify:			Specif		ite
2-0	be filed within 72 hours after death with the Maryland atal Hygiene. ad Hygiene. ad other then "neturel", or items 23a or 28e-f show other then "neturel", or items 23a or 28e-f show event, it a Medical Examiner man be mullied at	Completed	15. Decedent's E (Specify only highest gr	ducation		16a. Dece	dent's Usual Occupa	ation	t of working	16	Bb. Kind of B	7,1-2-	
7	ithin ser	npie	Elementary/Secondary (0-12)	College (1-4or	5+)		kind of work done of DO NOT use retired	)	or working		Own H	[omo	
2	e filed within al Hygiene. other then "		17. Father's Name (First, Middle, Last	1		Hone	maker	10 Motho	er's Name (First	Middle M			
anc	d be find he of	Be		,					Thompso		nueri Surnai	110)	
7	2 should be and Mental Is marked eumetic ev	2	Avery Testerman  19a. Informant's Name/Relationship	Type, Print)		19b. Maili	ng Address (Street a				City or Town	State, Zig	Code)
Me	and 2 paith a n 27 is ier treu		Bobby Gene Beaver	s (Son)		109	Fitzhugh :	Road,	Joppa,	Mary	land 2	21085	
Jre,	of Health of Health item 27 rother tr		20a. Method of Disposition	75	1 0	lace of Disperentery, cre	osition (Name of matory or other place	e) 1	Date	20	c. Location	- City or To	own, State
<u>Ĕ</u>	Pages ment of ent: If it ury or o		1   Burial 2 □ Cremation 3 □  Other (Speci		Ced	dar Hi	ll Cemete	ry M	larch26,	2005	Brookl	yn, l	Maryland
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should Department of Health and Men Importent: If item 27 Is marke any Injury or other treumetic once.		21. Signature of Funeral Service Lice	nsee	>	2	2. Name and Addres Br	s of Facilit	nski Fu	meral	Home,	P.A	
	70 2 % Q		23a Part From the disease, or com	aliantiana Ababaassa	d the death	D	1407 old	Easte	rn Aven	ue, E	ssex,	Mary.	land 21221 Approximate
			23a Part Errer the disease, or com shock or heart failure. List only Immediate Cause (Final	one cause on each	ine.	n. Do not en	ter the mode of dying	g, such as	cardiac or respi	iratory arres	ι,		Interval Between Onset and Death
er.	Physician /Medical		disease or condition resulting in death)	a. <u>COP</u>	D	(Ac							20 years
	Examiner			Due to (or as	s a consequ	uence or):							
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a conseq	uence of):							
	ocuted nd transi	Examiner	that initiated events	C									
760,	ate be executed nysician and he burial-transit		resulting in death) Last	Due to (or as	s a consequ	uence of):							
	physic physic the b	dical	•	d									
×	Attending Physicien: The law requires that the death certifical code and.  erdeath.  by the this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as the content of the code.	Completed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregna	ncy					23d. Da	ite of delive	erv
P.O. Box	death d for I	iciai	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a			□Ectopic pregnancy □ Other (specify)					onth	Day Year
0	by the	hys	9 Unknown	9□ Unknown									
S, I	w requires that been signed be should be det	Бу Р	Part II. Other significant conditions	contributing to death I	out not resu	ulting in the u	inderlying cause give	n in Part I.	. 23		_		ne cause of death?
ord	een s	ted	Lung Cancer	\ \ .						1 1 Yes	2 No	3 Prot	ably 4 Unknown
Vital Records,	elaw hasb	npie	Coronary Art	tery Dise	use				24	ta. Was an autopsy performe		Were auto prior to co death?	psy findings available mpletion of cause of
a E	n: Th licate r, pag			-						☐Yes 2【		1 🗆 Yes	2 No
<u> </u>	siciel s certil irecto	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	ent 2	ER/Outpatie	nt 3 DOA Othe	r	of Death (Chec rsing Home 5		о 6 ПОth	or /Socie	123
Division of	g Phy er this eral d	n; To	27. Manner of Death	28a. Date of Inju	ury	28b. Time o	f 28c. Injury	at			injury occur		9)
ion	andin ath. or: Aft	Certification:	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigatio	n	iy (Gai)	Injury	M 1□1	res 2 🗆 i	No				
<u>×</u>	r Atte	tific	3 Suicide 6 Could not be determined				reet, factory, office			cation (Stre		er or Rura	al Route Number,
۵	oitel o urs af rel D												
	To the Hospitel or Attending Physicien: The law within 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2.	edical		nysicien: To the best niner: On the basis of and manner si	of examinat								
	o the	Mec	29b. Signature and title of centrer	And mariner si			29c. License	number			. Date signe		
1	->-0		* CNN>	-la-			Dog	12.0	296	2	-23	5-2	005
	5		30. Name and address of person who	completed cause of	death (Item	23a) (Type,				1		. (	0:0 - 1
			Dr. Jason H. Bir	nbaum 9	000	Frank		are	Drive :	Balt	imore	Md	21237
	Sta Registra		31. Date filed (Month, Day, Year) MAR 2 4 2005	32. Regist	rar's Signa	ture					,		
DHA	1H 17 Rev 1/20		mait ≈ ± 2000	JANA J	J.S.	San Contraction of the Contracti				-	-		

			For State Registrar	State of Maryland		irtment of H		ind Menta		0 0 S	5	10002
			Decedent's Name (First, Middle, Last	)					e of Death			3. Time of Death
	Physici		Minnie Sus	an Bush				Man		23, 200	ear 5	4:50 a. M
	/Medic		4a. Facility Name (If not institution, give			4b. City, Town, or	Location o			4c. County of I	-	
	Laurini		Jacob's Well Ass	isted Living H	ome	Bel /	Air			Harf	ord	Co.
	Funeral		Social Security Number     6. Se	x 7. Age (In yrs. la	st birthday)	If Under 1 Year Months Days	If Under a	Min. (Mo	e of Birth orth, Day, Y	(ear) 9.	Birthpl	ace (State or Foreign
	Director		212 03 0343	□M 2□XF 90	Yrs.			May	19,	1914	Ma	ryland
	pur *		Usuel Residence of Decedent  10a. State 10b. County	10c, City	, Town or Lo	cation					10	d. Inside City Limits
	lanyla aho	ō		ore Co.	Baldı							1 ☐ Yes 2 ☑ No
	the A	ect	10e. Street and Number	101 6 00.	Dara	10f. Zip Code			100	. Citizen of Wha	at Coun'	ıry?
	with Be or	<u>ā</u>	13525 Fork Road				21013	3		United	Sta	ites
	Jeath Ins 23	era	11. Marital Status	12. Was Decedent Ever in U.S	S. 13. V	Vas Decedent of Hi f Yes, specify Cuba			s or No-	14. Race -	America	an Indian,
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f ahow or other traumatic event, the Medical Examinar must be notified at	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Yes, specify Cuba □ Yes 2X□ No	n, Mexican Specify:	, Puerto Hican,	etc.)	Specify:	white, e Whit	
ğ	2 hou	ted	15. Decedent's Edi	ucation	16a. Deced	lent's Usual Occupa	ation	af washing	16	b. Kind of Busin	ess/Ind	ustry
21.5	9. n. n Med	Completed	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	kind of work done of OO NOT use retired	)	or working		•		
7	filed with Hygiene. Ither than	Con	6 yrs.			Homemaker		····		0wn	Home	9
Maryland 21215-0036	should be file and Mental Hy marked oth umatic event	To Be	17. Father's Name (First, Middle, Last) Henry Morgan				18. Mothe	r's Name <i>(First,</i> na Smi		iden Sumame)		
ary	2 should and he is man		19a. Informant's Name/Relationship (T		19b. Mailin	g Address (Street a	and Numbe	r or Rural Route	Number, C	City or Town, Sta	te, Zip	Code)
Σ	1 and 2 Health a tem 27 ic		Mr. Robert J. Bush		And the second	5 Fork Ro	ad B	Baldwin,	-		1013	
ore	of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	CO	ace of Dispo imetery, cren	sition (Name of natory or other plac		Date		c. Location - Cit	•	
Ĕ	Pag ment ant: I		* 4 Donation 5 Dother (Specify,	Most		edeemer Cem	. C	3/26/20	05	Baltimo	re,	Maryland
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other 2006e.		21. Signature of Funeral Service Licens	º⁰ Michael E. Cana -/-		. Name and Addres Leonard J				5 Harfo timore,		Road 21214
	賽 象		23a. Part1. Enter the disease, or composition of the shock, or heart failure. List only of	na causa on each line			g, such as	cardiac or respi				Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition	. HUPO	RTEL	15:02						Onset and Death
	/Medical		resulting in death)	Due to (or as a consequ		,						
	Examiner		Sequentially list conditions,	b	UKB							
1/	pe tis	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	erios offi.							
V	and I-tran	хаг	that initiated events resulting in death) Last	c.  Due to (or as a consequ	ence of):						=	
8760,	icate be executed physicien and s the buriat-transit	alE									Ī	
687	tificate ig phys as the	alc		o								
Вох	nding use a	N/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnar		3=				23d. Date of	of delive	ry
m.	that the death certif ed by the attending detached for use as	Physician/Medical	in the past 12 months?	1 Live birth 2 Fetal 4 Pregnant at time of de		Ectopic pregnancy Other (specify)				Month		Day Year
P.0	by the	hys	9 Unknown	9□ Unknown								
rds, I	es Be	by	Part II. Other significant conditions co	ntributing to death but not resu	Iting in the u	nderlying cause give	en in Part I.		e. Did toba 1 □ Yes			e cause of death? ably 4 Unknown
2	s been si should!	Completed						24	a. Was an	24b. We	re autor	osy findings available
Re	The lav	Eo						115	autopsy performe Yes 2	ed? dea	ith?	npletion of cause of 280 No
ta		a	25. Was case referred to medical				26. Place	of Death (Chec		2110		ALDRIS WELL
>	ysici is ce direc	To B	examiner? 1 ☐ Yes 2 ☐ ¥fo	Hospital: 1   Inpatient 2   E	ER/Outpatien	t 3 DOA Oth	er: 4□ Nu	rsing Home 5	Residen	ce 8 Other	(Specify	175 -2705
0 0	Attending Physician: r death. ector: After this certific by the funeral director,		27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Worl	k?		scribe how	injury occurred		
Sio	vttendia death. ctor: A ctor: A y the fu	catic	2 Accident investigation				Yes 2 1					
Division of Vital Record	al or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify,	me, farm, str )	eet, factory, office			cation (Stre y or Town,	et and Number ( State)	or Rurai	l Route Number,
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	edical C	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exem	ysician: To the best of my know iner: On the basis of examinati and manner stated.	wledge, death ion and/or in	n occurred at the tin vestigation, in my o	ne, date an pinion, dea	d place, and due th occurred at th	e to the cau se time, date	ise(s) and mann e and place, and	er as sta	ated. the cause(s)
	To the within 2. To the complet	Me	29b. Signature at 111 e o certifies			29c. Licens	e number	,	290	d. Date signed (/	Month, I	Day, Year)
	- > PP 0		DIS HILL	m)		103	6841	6	my	mit 2	3, 2	2005
	/		30. Name and address of person who o	completed cause death (Item	23a) (Type,	Print)	-				-	
	5		SERAMO H. RY  31. Date filed (Month, Day, Year)	WIF MIN	5601	Louit RAV	on sh	10 BA	7 Ti Mur	I MI	7	212-39
	Sta Registi		MAR 2 4 200	Registrar's Signat	Lynn	A STATE OF THE STA						

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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death **Physician** MARCH 21. 9:13 A 2005 STEPHEN LEE BENNETT /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner NORTH ARUNDEL HOSPITAL GLEN BURNIE ANNE ARUNDEL If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. Months M 2 F Yrs. Director 49 PA 115.48.2687 MARCH 5, 1956 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits If item 27 is marked other then "natural", or items 23s or 28s-1 show or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Completed by Funeral Director MD ANNE ARUNDEL GLEN BURNTE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 549 MUNROE 21061 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Sonet Stere 1 Never Married 2 Married 1 Yes ZNo 3 ☐ Widowed 4 ☑ vivorced Il Hygiene. WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) MECHANIC STATE GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) s 1 and 2 should be fi f Health and Mental H tem 27 Is markad ott ၉ unk HELEN BENNETT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health Item 27 I ELAINE ARCHIBALD 549 MUNROE CR GLEN BURNIE, MD 21061 20b. Place of Disposition (Name of 20a Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot once. BAYVIEW CREMATORY 1 Burial Cremation 3 Removal from State 4 Donation 5 Other (Specify) 3.25.2005 BALTIMORE, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility FINK FUNERAL HOME, P.A. 426 CRAIN HWY SW GLEN BURNIE, GREGORY MO1148 Approximate Interval Betweek Onset and Deat 23a. Part. Enter the disease or shook, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respirator, only one cause of each line. Immediate Cause (Final Myoc C 9/ **Physician** minut disease or condition resulting in death) /Medical Due to (pr/as a consequence of); Examiner thing Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Que to (or as a consequence of): ed by the attending physician and detached for use as the burial-transit mar that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 24a. Was an 2 No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? er of Death 28b. Time of 28d. Describe how injury occurred Hospital or Attending Injury 1 Natural 5 Pending 1 Yes investigation 2 Accident Diractor 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital c within 24 hours af To the Funeral D completely filled in 29a. Certifier f Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannagestated. (Check only

State Registrar

DHMH 17 Rev 1/2001

29b. Signatura a

30. Name and address of person who con

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31. Date filed (Month, Day, Year)

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se of death (Item 23a) (Type, Print)

32 A gistrar's Signature

29c. License number

29d. Date signed (Month: Day, Year

			1- For State of Maryland / E	Department of Health and Mental Hygi  Certificate of Death	iene 1005 10004
	Physic		1. Decedent's Name (First, Middle, Last)	R)   2. Date of Death	Day Year 3. Time of Death
1	/Medi Exami		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	20 2005 12:45 M 4c. County of Death
	Funeral Director		5. Social Security Number  5. Social Security Number  1	hday) If Under 1 Year   If Under 24 Hrs. 8, Date of Birth Months Days Hours Min. Hydony Day.	Year 5 Birtholace (State or Foreign
	ith the Maryland or 28a-f show	ctor	10a. State 10b. County 10c. City, Town BALL	MORE	10d. Inside City Limits _1276s 2 ☐ No
	th with the 23a or 2	Funeral Director	10e. Street and Number BUDGIE St.	10f. Zip Code 10	g. Citizen of What Country?
9600	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene, item 27 is marked other than "natural", or liems 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at	þ	11. Marital Status  1 Never Married 2 Married  3 Novidowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 ☐ Yes 2 Storo Specify:	14. Race - American Indian, Black, White, etc.
21215-0036	filed within 72 h Hygiene. rther than "nati	Completed	Elementary/Secondary (0-12) Pollege (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of working life. DONOT use retired)	6b. Kind of Business/Industry  HOME
Maryland	shoutd be fil ind Mental H is marked ott umatic even	To Be	17. Father's Name (First, Middle, Last) HENRY AUSSE!	18. Mölher's Name (First, Midelle, Mi	aiden Sumaine)
	1 and 2 sho Health and tem 27 is m		Shirley A. Kimball(OAUGNER) /U	Mailing Address (Street and Number of Rural Route Number)  Disposition (Name of Date 2	1.M. 2123
Baltimore,	Page ment c		Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	Compatoly or other place) 3-38-65 2	Oc. Location City or Town State
Ba	permit. Deportr Importa		Mithia P. Lalmare	22. Name and Address of Facility JUSEPH (3)	18 15 No 4 (4011) E0 110 212 02)
	Physician		23a. Part Lenter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)	of enter the mode of dying, such as cardiac or respiratory arres	st, Approximate Interval Between Onset and Death
58760,	ficate be executed  Medical  Examine  bhysician and  sthe burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of	aswar auclent	oneyear
. Box 6	death certi e attending id for use a	by Physician/Media	IF FEMALE: 23b. Was decedent pregnant in the past 12_months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of delivery Month Day Year
rds, P	The law requires that the ate has been signed by the bage 2 should be detached.		Part II. Other significant conditions contributing to death but not resulting in t	the underlying cause given in Part I. 23e. Did tobac	cco use contribute to the cause of death?
ital Records,	n: The law re ficate has bee nr. page 2 sho	Completed		24a. Was an autopsy performe 1 □ Yes 2 및	24b. Were autopsy findings available prior to completion of cause of death?  No 1 Yes No
Division of Vit	or Attending Physician: The lav ther death. Director: After this certificate has in by the funeral director, page 2	atlon: To Be	25. Was case referred to medical examiner?  1   Yes   25   No	me of 28c. Injury at 28d. Describe how	
Divis	ital or Attenders after death al Director:	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office 28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
	To the Hospital within 24 hours a To the Funeral C	Medical	one) and manner stated.	death occurred at the time, date and place, and due to the caus or investigation, in my opinion, death occurred at the time, date	ee(s) and manner as stated.  and place, and due to the cause(s)
	To To com	2	29b. Signature and title of certifier  MATAL KUNTYT		Date signed (Month, Day, Year)  ATCh 20, 2005
	5		30. Name and address of person who completed cause of death (Item 23a) (T)	ype, Print) TREET AFARTMENT 373 BACT	TOPE TARINA
2754	Stat Registra	e ar	31. Date filed (Month, Day, Year) MAR 2 4 2005 32. B Sistrar's Signature	Spelle	10 1-2 C LIMPSCHON CLITZ

State of Maryland / Department of Health and Mental Hygierle [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year Mildred Billings /Medical 10, 2005 March 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Clinton

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Nov. 3, 1920 Southern Maryland Hospital 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) 1 M 2 XF 89 Director 224-05-8385 North Usual Residence of Decedent the Maryland 10a, State "netural", or items 23a or 28a-f show dical Examiner must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Xes 2 No Md. PG Upper Marlboro 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code with 1 9225 Goldenrod Lane death Funeral 20772 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, iif. Pages 1 and 2 should be filed within 72 hours after ortment of Health and Mental Hygiene. crtant: If Item 27 is marked other than "netural", or item injury or other treumatic event, the Medical Examinal Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: ģ Belia:ck 3 ₩idowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Domestic Worker Private Ind. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Unknown Willie Lee Scott ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wilma Smith (Daughter) 9225 Goldenrod Lane, Upper Marlboro, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 19 Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) 3/17/2005 Landover, Maryland Harmony Mem. Park 22. Name and Address of Facility Tri-State F/S/Inc 21. Signature of Funeral Service Lights Third St.NW., Wash.D.C. 20001 Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final ABDOMINAL Onset and Death omov/hape **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner to, lune Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transit and Due to (or as a consequence of): Box 68760, the attending physician hed for use as the buria death certificate be an/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Physici 4☐Pregnant at time of death Month Day Year P.O. I 5 Other (specify) ☐Yes 2 No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 23e. Did tobacco use contribute to the cause of death? Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No has autopsy performed' certificate 2 No Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: P 1 Yes 2 No this 1 KInpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 Accident 5 Pending investigation after death.

Director: Aft in by the fur 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) à 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \ Homicide within 24 hours a To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 131206 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William IAN NO M 31. Date filed (Month, Day, Year) State Registrar

-			For State	State of Marylan		artment of He		Mental Hy	7005	10006
			Registrar  1. Decedent's Name (First, Middle, Las	st)	Cei	Tillicate of L	Jeani	2. Date of De	Reg. No.	3. Time of Death
	Physici		MARY /	- cos-	70N			MARCI	Day Yea	5 14:55 PM
	/Medic Examin		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, or I	Location of Dea	th	4c. County of D	
			5. Social Security Number 6. S	ex 7. Age (In yrs.	last birthday)	tf Under 1 Year	If Under 24 Hrs	s. 8. Date of Bir	rth 9.1	Birthplace (State or Foreign
	Funeral Director		240-38-1348 1	□M 2/2F	70 Yrs.	Months Days	Hours Min	MARCH	30,1929 N	CAROLINA
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
	Many B-f sho	tor	MD NA	Ba	Itimor	e				1 ✓ Yes 2 ☐ No
	filed within 72 hours efter death with the Maryland Hyglene. ther then "natural", or Items 23a or 28a-f show ther then "natural", or Items 23a or 28a-f show ont, the Medical Examinating 18	Funeral Director	10e. Street and Number	ave.		10f. Zip Code	2		10g. Citizen of What	Country?
	ms 23	neral	11. Marital Status	12. Was Decedent Ever in U.	.S. 13.	Was Decedent of His	spanic Origin? (	Specify Yes or No	o- 14. Race - A Black, W	merican Indian,
ð	or Its	by Fur	1 Never Married ,2 Married	Armed Forces?  1 Yes 2 No tf Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:	no moan, etc.,	Specify: Q	lack
ğ	"natural",		3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Ed		16a. Dece	dent's Usual Occupa	tion		16b. Kind of Busine	ss/Industry
215-0036	i within 72 hours efter de liene. r then "natural", or Items tra Medical Examinar n	Completed	(Specify only highest gra	Coltege (1-4or 5+)	Give life.	kind of work done do DO NOT use retired)	uring most of wo	orking	Home	
2	be filed w ntal Hygier ed other the		17. Father's Name (First, Middle, Last)	)	House	WIFE	18. Mother's Na	ame (First, Middle	e, Maiden Sumame)	
and	a la b	To Be	Elijah Nixon				Parmil	llie Di	xon	
Maryland	2 should and Men Is marke reumatic		19a, Informant's Name/Relationship (	1. 1	19b. Mailii	_ ^ /			per, City or Town, State. MD 2/20	
	1 and Health Iem 27 other tr		20a. Method of Disposition	- NUSDANA	tace of Dispo	sition (Name of		Date	20c. Location - City	
ē	Pages nent of I ant: If Ito		1 Burial 2 □ Cremation 3 □ 4 □ Donation 3 □ Other (Specif	JHemovat from State	emetery, crei	matory or other place	1.A. 3-	30-05	Owings 1	Mills, MO
Baitimore,	permit. Pages 1 and 2 should Department of Health and Men Importent: If Item 27 is marke any Injury or other treumatic <u>once</u> .		21. Signature of Juneral Service Ucer	1506	Ba	2. Name and Address	a of Equilibra			0. MD 21839
			23a. Party. Eprey the disease, or com shock, or yeart failure. List only	plications that caused the deati one cause on each line.	h. Do not en					Approximate Interval Between
)	Physician		Immediate Cause (Final disease or condition	a. CORONANY Due to (or as a conseq	ARTE	MI DISE	EMSE	*		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):	·				
1/	ed ssit	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence of):					
٧ آ	executin and ial-tran	Examiner	that initiated events resulting in death) Last	C. Due to (or as a conseq	uence of):					
2/60	eath certificate be executed attending physician and for use as the burial-transit	lical	(	d					· · · · · · · · · · · · · · · · · · ·	
Q X	certific Iding p	/Mec	IF FEMALE:	23c. If yes, outcome of pregna					23d. Date of	delivery
). Box	atter for u	Physician/Med	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown		Ectopic pregnancy Other (specify)			Month	Day Year
J O	hat the		9 Unknown  Part II. Other significant conditions of	contributing to death but not res	ulting in the u	nderlying cause give	en in Part t.	23e. Did	tobacco use contribut	e to the cause of death?
ecords,	n requires that the de been signed by the should be detached	ed by						10	Yes 2□No 3□	Probably 4 Honknown
ဝပ္ပ	e law rei has bee je 2 sho	ompleted						24a. Was	s an 24b. Were prior	autopsy findings available to completion of cause of
II G	The page	O						1 ☐ Yes	ormed? death	
VItal		o Be	25. Was case reterred to medicat examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2	ER/Outnatie	nt 3□ DOA Othe	N. Pr	eath (Check only Home 5 □ Bes	one) idence 6 Other (5	Spacify)
n ot	ng Phys fter this neral di	on; To	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	f 28c. Injury Work	at		how injury occurred	,
DIVISION	or Attending ifter death. Diractor: After in by the fune	icatle	2 ☐ Accident investigatio	OP Dines of thisses At he	ome tarm st		/es 2□No	28f. Location	(Street and Number of	Rural Route Number.
2	el or A s after il Dirac id in by	Certification:	4 Homicide determined	building, etc. (Specif	(y)	reet, tactory, office			own, State)	
	To the Hospitel or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	edical (	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Example (Check only one)	nysician: To the best of my knominer: On the basis of examina and manner stated.	owledge, deat ition and/or in	h occurred at the tim vestigation, in my op	e, date and place sinion, death occ	ce, and due to the curred at the time	e cause(s) and manne , date and place, and	r as stated. due to the cause(s)
	To the To the Comple	Me	29b. Signature and title of certifier		-	29c. License			29d. Date signed (M	onth, Day, Year)
			Exima m	- 004/10000	1.0.		54739	1	MARCH.	2311 2005
	2		30. Name and address of person who	completed cause of death (Item			we. n	namla.	nd 2121	5 .
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	t a	the state of the	in refrees	7 60	
	Registi	rair	MAR 2 4 2005	Breuz B.	Con the last					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2005 March 22, **Physician** URRENS WRENCE 11:00a M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 1921 Whistler Avenue Baltimore N/A If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) May 25, 1924 9. Birthplace (State or Foreign 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) **Funeral** ₩ 2 F Maryland 80 217-16-6117 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b County 28a-f ahow the Medical Examiner must be notified at 1. Yes 2 No Maryland N/A Baltimore Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō USA 21230 1921 Whistler Avenue Items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2\tilde{\text{D}} No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. s 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 9 3℃ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Machinist Koppers Inc. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Linker Currens Margaret Tyson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2029 Maisel St., Baltimore, MD 21230 Janet C. Armalis 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Pages ment of I 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any njury or once. Loudon Park Cemetery 3/25/05 Baltimore, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licenses 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part1. Eater the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 100 Sequentially list conditions, Due to (or as a consequence of) Examiner if any, leauning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last use as the burial-transit Due to (or as a consequence of): P.O. Box 68760. nding physician certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year for in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown cate has been signed by i page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 9 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performe 2 No 1 Yes 1 Yes Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Other: 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 📉 No 2 ER/Outpatient 3 DOA 1 Inpatient 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attanding Paffer death. Natural 5 Pending 1 🗌 Yes 2 🗌 No investigation 2 Accident 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral E Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of dertifier pleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who con CUN 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2005

	1	For State Registrar	State of Ma		partment of Health and ertificate of Death	Mental Hygier	2005 1000
Physician /Medical Examiner	1	1. Decedent's Name (First, Middle, Li Line Community (First, Middle, Li Lia. Facility Name (If not instrution, gi	ve street and number)	0.0	4b. City, Town, or Location of De	march	Day Year 3. Time of Do. 20 2005 2325
Funeral Director	2	Baltimore 5. Social Security Number 6. 244-28-9606  Usual Residence of Decedent	Sex 7. Age	S Attais (In yrs. last birthday 76 Yrs.			
s 23a or 28a-f show oust be notified at erai Director		MD NA		10c. City, Town or L Bal	ocation timore		10d. Inside City
23a or 28a-f si ast be notified	מו	10e. Street and Number 3338 Brendon Avenu	ue		10f. Zip Code 21213	10g.	Citizen of What Country? USA
at', or Item	5	Marital Status     Never Married 2  Married     Midowed 4  M∑Divorced	12. Was Decedent E Armed Forces? 1 X Yes 2 □ N If Yes, Give Year or Dates:	Ever in U.S. 13.	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Put 1 ☐ Yes 2 ☒ No Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: Black
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f Health and Mental Hygiene. itam 27 Is marked other than other traumatic event, the M. To Be Comp	ם ו	7. Father's Name (First, Middle, Las Garland Clark	t)		18. Mother's N	ame (First, Middle, Maid la Council	
of Health and I itam 27 Is me other trauma		19a. Informant's Name/Relationship Angelia Morrison/ Nic		4704	ing Address (Street and Number or Bonnie Brae Road. P	ikesville, MD	21208
Department of Hi Important: If itan any injury or oth once.		20a. Method of Disposition  1 X Burial 2 ☐ Cremation 3 [  4 ☐ Donation 5 ☐ Other (Speci	fy)	Crownsvill	e Veteran Cem. 03-2		Location · City or Town, State  Crownsville, MD
Depa Impo any ii once	_	21. Signature of Funeral Service Lice  1. Signature of Funeral Service Lice  23a. Part 1. Enter the disease, or conshook, or heart failure. List only	nplications that caused	the death. Do not er			or St. Baltimore, MD Approximate Interval Between
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. Nø. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** A128 2005 March /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltmere cal N/A If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex 9. Birthplace (State or Foreign **Funeral** Days Months 1 M 2 F Yrs 216 58 2749 58 MAR. 07, 1947 MARYLAND Director Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10a State 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28e-f show other treumetic event, the Medical Examinator must be mailfied at 1 Yes 2 No Director BALTIMORE MD. N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 346 S. DALLAS COURT 21231 U.S.A. death by Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: Specify: 3 ☐ Widowed 4 ☐ Divorced BLACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry at Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 7TH DISABLED N/A permit. Pages 1 and 2 should be file Department of Health and Mental Hy; Importent: If item 27 Is marked othe any injury or other treumetic event, once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) WINSTON CAREY HELEN KILLEBREW 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 230 S. SPRING COURT BALTO, MD. CATHERINE HANSON (SISTER) 21231 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State t∑ Burial 2 ☐ Cremation 3 ☐ Removal from State MT.ZION CEMETERY 4 Denation 5 Other (Specify) MAR. 28, 2005 BALTIMORE, MD. ure of Funeral Service Licenses 22. Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME madere 1412 E. PRESTON ST. BALTO, MD. 21213 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Previocy sto Immediate Cause (Final mee morra **Physician** 8 days disease or condition resulting in death) /Medical Examiner keen Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner death certificate be executed burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical the 1 as IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy õ in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy 2 No 1 Yes To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 2 ER/Outpatient 3 DOA ě 2 Inpatient this filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manne of Death 28d. Describe how injury occurred Certification: After Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No s after death 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Momicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier and manner stated. within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License numbe son who completed cause of death (Item 23a) (Type, Print) address of p PAUL ST. 301 31. Date filed (Month, Day, Year) MAR 2 3 egistrar's Signature State 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State RegistrarAMEND ITEM #26 PER PHY G841 Sezifioste 10f Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Da MARTHA B. 22,2005 MAR. 3:06 A M /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 5812 BLAND AVENUE BALTIMORE 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min Months Days Hours 1 □ M 2 🙀 F 63 Director 219 38 8782 13,1941 SOUTHCAROLINA Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or items 23a or 28a-f shov the Medical Examinatives by notified at 1 Yes 2 No Director MD. N/A BALTIMORE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 1601 woodbourne Avenue 21239 death v U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo Specify: Specify: BLACK à 3 ☐Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72 the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nate any injury or other traumatic event, the Medical 16b. Kind of Business/Industry BALTIMORE CITY DEPT. Elementary/Secondary (0-12) College (1-4or 5+) TEACHER EDUCATION 4 vrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ULYSSES DUBOSE SR. ELLA MILLINGS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CRESTA STERRETT ( DAUGHTER ) 5812 BLAND AVENUE BALTIMORE MD. 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Donation 5 Other (Specify) GarrisonForestCemeteryMarch31,2005Owings,Mills, MD ature of Funeral Service License CALVIN B. SCRUGGS FUNERAL HOME PRESTON STREET BALTO, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death m Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as donsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that juit and apports.) sequence of): Due to (or as a co Examiner burial-transit that initiated events resulting in death) Last certificate be execu Due to (or as a consequence of): P.O. Box 68760 Physician/Medical as the esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) detached the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ SPANO 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy 1 🗌 Yes 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Daughter's Res Other: 4 Nursing Home sidence Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Certification: 1 Natural 2 Accident 5 Pending within 24 hours after death. To the Funeral Director: A investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

State

Registrar

30. Name and address

31. Date filed (N

00

th, Day, Year)

MAR 2 4 2005

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rson who completed cause of death (Item 23a) (Type, Print)

#32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1 Decedent's Name (First, Middle, Last) Day Year Month **Physician** Dabyws Ki
4b. City, Town, of Location of Death Marc 22 2005 0845 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Cty If Under 24 Hrs. The Johns Hopkins

5. Social Security Number Bultimoru Hospital n/a Year Days 8. Date of Birth (Month, Day, Year) May 11 1 If Under 1 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 2▼F Months Hours Min. MD 217-04-9647 36 **Director** Usual Residence of Decedent death with the Maryland 10c, City, Town or Location 10d. Inside City Limits 10a State 10b. County item 27 is marked other then "neturel", or items 23s or 28a-f show other treumatic event. I're M. JIS. Exp. ill ref in the inclined at 1 ☐ Yes 🏖 ☐ No Directo Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 31 Belfast Rd. 21093 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should ba filed within 7 th and Mental Hygiene. 7 Is marked other then "r Elementary/Secondary (0-12) College (1-4or 5+) 4 12 Quality Assurance Rep. Health 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Horace N. Porter ည Martha S. Reuwer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Importent: If item 27 is m shy njury or other treum <u>Jeffrey M. Dzbynski/husband</u> 31 Belfast Rd., Timonium, MD 21093 20a. Method of Disposition. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 2 Re 4 Donation 5 Other (Specify) 3/24/05 → □Removal from State Dulaney Valley Memorial Gardens Timonium, MD Fapered ica Licentee 22. Name and Address of Facility Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Respiratory Failure
Due to (or as a mesequence of): Iweeks disease or condition resulting in death) /Medical Examiner Metastatic Breast Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Live birth 2 Fetal death in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2**X** No 1 ☐ Yes Hospital or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 1 Pinpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Natural 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No death, investigation ☐ Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 24 hours a 29a. Certifier 1 🕰 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Medical Opertor RES-000 March 22, 2005 30. Name and ad ss of person who completed cause of death (Item 23a) (Type, Print) Avril Majure, Johns Hopkins Hospital, Tower 110, Doctor's Lounze, 600 North Wolfe Street, Battimore, MD 21287
31. Date filed (Month, Day, Year) 32. Registrar's Signature 32. Registrar's Signature State Registrar

	-	For State Registrar		State of Ma	ryland /	-	rtment of F				giene Reg. No	21115	10012
		Decedent's Name (First,	Middle, Las	1)		-				2, Date of De			3. Time of Death
Physicia /Medic		Laura	Tres	sa El	lingto	n				May	CM	2 300	
Examin		4a. Facility Name (If not ins	stitution, give	street and number)			4b. City, Town, o	r Location	of Death	(0)	40	County of Dea	ith
		5. Social Security Number	1-2S	Health	(In yrs. last I	Phirthday)	If Under 1 Year	I Unde	1 24 Hrs.	8. Date of Bir	th.	N/A	rthptace (State or Foreign
Funeral Director		218-44-8097		¬., ., -X-	9	Yrs.	Months Days	Hours	Min.	(Month, Da	v. Year	1945 Mai	ountry)
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Ba-f s	ecto	MD	N/A		Balti	more	10f, Zip Code				10a Ci	itizen of What C	
with t	Funeral Director	10e. Street and Number 2347 Washing	oton B	lvd.			21230				rog. O	USA	odiniy.
death	era	11. Marital Status	50011 2	12. Was Decedent E	ver in U.S.	13. V	Vas Decedent of H Yes, specify Cubi		rigin? (Spe	city Yes or No	D-	14. Race - Am	
if e, INITION INITION AT INITIONS OF A STAND AND A STAND A STA	by	1 Never Married 2[3 Widowed 4X Di	_	Armed Forces? 1 ☐ Yes 2 🖾 N If Yes, Give Year or Dates:	0	1	Yes, specify Cub:			Rican, etc.)		Black, Whi	
72 ho	Completed	15. De (Specify only	ecedent's Ed	ucation de completed)	16	Sa. Deced	ent's Usual Occup kind of work done OO NOT use retire	ation during mo	st of worki	ng	16b. F	Kind of Business	s/Industry
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traumatic ever	Ĕ	19a. Informant's Name/Re Elizabeth E.	, ,	ype, Print) (Daught			g Address (Street Perfect						
TC, IV	}	20a. Method of Disposition			20b. Place	of Dispos	sition (Name of natory or other pla	ce)	D	ate	20c. L	ocation - City or	r Town, State
Pages bent of nt: If i		1 ☐ Burial 2XI Cren  1 ☐ Donation 5 ☐ O			1	, .	rk Cemet		Mar. 2	26, 05	Ba	ltimore	City
Datumore, permit. Pages 1 an Department of Heal Important: If them 2 any injury or other		21. Signature of Funeral S	Service Licen	shlan	gu	,	Name and Addre		Lo			Funeral	
		23a. Part 1 Enter the dise shock, or heart failur	ase, or comp	olications that caused	the death. D	o not ente	er the mode of dying	ng, such a	s cardiac o	r respiratory a	rrest,	- FID - 6-1-6-1	Approximate Intervat Between
Physician		Immediate Cause (Final disease or condition			BABU		CARDIAC						MINUTES
/Medical Examiner		resulting in death)		Due to (or as a	consequenc	ce of):							
LAGITITICI	_	Sequentially list condition if any, leading to immedia cause. Enter Underlying	s,	b. Due to (or as a			4 (HYPE	RTRO	PHIC	CARDIC	omy	OPATHY)	YEARS
bear Insit	Examiner	Cause (Disease or Injury	~ <				CUCTIVE	PULN	10NA	RY DIS	EAS	SE	YEARS
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To the Hospital or Attending Physician: The law requires that the death cartificate be executed within 24 hours after death.  To the Funeral Director: After this cartificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregn	iant	23c. If yes, outcome of 1□Live birth			Ectopic pregnanc	y				23d. Date of de	elivery Day Year
vrequires that the death car baen signed by the attendin should be detached for usa	hysici	in the past 12 month 1 □ Yes 2 2 No 9 □ Unknown		4□Pregnant at 9□ Unknown			Other (specify) _						
igned be de	by	Part II. Other significent	conditions co ペルチのS		it not resultin	g in the ur	iderlying cause gi	ven in Part	ł I.		Yes 2	- 57	to the cause of death?  Probably 4 Unknown
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has b	Completed			BLADDE	R CA	NCE	~			24a. Was		prior to	utopsy findings available completion of cause of
VICIAN: The certificate rector, pag	- 1		HMA					00 DI-		Yes	2 N	0 1 XYe	s 2 No
oician: Certifica	o Be	25. Was case referred to examiner?  1 Yes 2 No		Hospital:	ot 2 DER/	Outpatien	t 3 DOA Ot	ha=		n (Check only		6 ☐Other (Spe	ecify)
tending Physician: The lar tending Physician: The lar tor: After this certificate has the funeral director, page 2	tion; To	27. Manner of Death	Pending investigation	28a. Date of Injur (Month, Day	v 28	b. Time of Injury	28c. tnju Wo			28d. Describe			
LIVISIO I or Attendi after death. I Director: A d in by the fu	Certification;		Could not be determined	28e. Place of thic building, etc	iry - At home . (Specify)	, farm, str	eet, factory, office			28f. Location City or To	(Street a	and Number or F te)	Rural Route Number,
To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one)	Certifying Ph Medical Exam	ysicien: To the best on niner: On the basis of and manner sta	examination	dge, death and/or inv	occurred at the tivestigation, in my	ime, date a opinion, de	and place, and place, a	and due to the ed at the time	cause(: , date ar	s) and manner a nd place, and du	as stated. ue to the cause(s)
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16		30. Name and address of	person who	completed cause of de	eath (Item 23	a) (Type,	Print)	1 1		и л		20-	MA.DITM
[ E		31. Date filed (Month, Da	V. Year	32. Registra	ar's Signature	700	LMIUN	KIV	E	13461	/M	URESI	mn 2/27/
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State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TIMOTHY LOW M. D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204
31. Date filed (Month, Day, Year) 32. Registrar's Signature filmer & from

			State of Mary  State Registrer		artment of H rtificate of L			giene Reg. Ng?	05	10014
	9 3		Decedent's Name (First, Middle, Last)				2. Date of De Month		Year	3. Time of Death
	Physicia /Medic		James H. Fraley				March	23, 2	2005	5:40 A <sup>M</sup>
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Pasade:		1	4c. County		undel
			2080 Kurtz Avenue  5. Social Security Number 6. Sex 7. Age (In	yrs. last birthday,	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h		place (State or Foreign
	Funeral Director		213-30-5237 <sup>1</sup> ♠ <sup>2</sup> □ F	71 Yrs.	Months Days	Hours Min.	July 5	, 1933	Virg	ginia
	D .		Usual Residence of Deceden!           10a. State         10b. County         10	c. City, Town or L	ocation					10d. Inside City Limits
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	the N 28e-f	rect	Maryland Anne Arundel	rasaue	10f. Zip Code			10g. Citizen of	What Cou	ntry?
	3a or	<u>I</u>	2080 Kurtz Avenue		21122		4	USA		
Maryland 21215-0036	d within 72 hours after death with the Maryland piene. rr than "naturel", or Items 23a or 28e-f show the Madical Examiner must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent Ever Armed Forces? 1 Yes, 2 No If Yes, Give Year or Dates:	in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2X No	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	Bla	ce - Ameri ck, White, y:Whit	
2-0	72 ho natur	ted	15. Decedenl's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupa	ition uring most of wor	king	16b. Kind of B	usiness/Ir	ndustry
2	within lene. than "	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		kind of work done of DO NOT use retired NESSMAN	) "	ŭ .	Contra	ctino	g / Salvage
2	e filed w it Hygier other ti		17. Father's Name (First, Middle, Last)	Dusti	lessilari	18. Mother's Nar	ne (First, Middle,			5 / Darvage
lan	s 1 and 2 should be filled f Health and Mental Hyg item 27 le marked othe other treumetic event,	To Be	Carl H. Fraley			Sara	ah Hamil	ton		
ary	shou and M e mar		19a. Informant's Name/Relationship (Type, Print)		ing Address (Street a					
Σ,	s 1 and 2 of Health a item 27 le other trei		Bridgette R. Fraley, Wife		Kurtz Ave					
ore	ges 1 it of H if iter or off		1 Burial 2 Cremation 3 Hemoval from State		osition (Name of matory or other place	1	Date	20c. Location	•	
altimore,	permit. Pages 1 Department of Inportent: If ite any injury or ot		* 4 □Donation 5 □ Other (Specify)  21. Signature of Funeral Service Loepsee	Metro G	rematory I	nc. U3/2	4/05			Maryland
Ba	permi Depar Impor any ir		Thomas Gregor		2. Name and Addres Cremation 299 Freder	Sociéty ick Road	Of Mary 1 Baltim	land Indore, Mar	c. rylar	nd 21228
П			23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	death. Do not en	ter the mode of dying	g, such as cardiad	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	atoce!	10/0/	None				
ï	Examiner		Due to (or as a co	insequence of):						
		ler	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	onsequence of):						
ľ	cuted nd ransit	Examiner	that initiated events c.							
8760,	icate be executed physician and s the burial-transit		resulting in death) Last Due to (or as a co	insequence of):						
876	cate b physic the b	edical	d							
.O. Box 6	ath certif ttending or use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)				ate of deliv	rery Day Year
<u>α</u>	res that the de signed by the a be detached f		Part II. Other significant conditions contributing to death but no	ot resulting in the	underlying cause give	en in Part I.	23e. Did t	obacco use con	tribute to	the cause of death?
rds	-= 0, 73	ed by					10	Yes 2□No	3 □ Pro	bably 4 □Unknown
of Vital Records,	The ate h page	Completed					24a. Was autor perfo 1 🗆 Yes	rmed?	Were autoprior to codeath?	opsy findings available ompletion of cause of
Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	2 □ ER/Outpatie	other actions of the	ACT.	ath (Check only o		(C	(4.)
of		7: To	27. Manner of Death 28a. Date of Injury		III 3LI DOA	4 🔲 Nuising i	lome 5 Resi	how injury occur		197
ion	Attending P r death. ector: After t by the funera	atlo	2 Accident investigation	oar) Injury		res 2 □ No				
Division	or Atte after de Directo	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury building, etc. (\$	At home, farm, s Specify)	treet, factory, office		28f. Location (. City or To	Street and Numl wn, State)	er or Rur	al Route Number,
)	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of many and manner stated	amination and/or i						
)	To the within To the comp	M	29b. Signature and title of certifier		29c. License	number		29d. Date signe	d (Month,	Day, Year)
	10		30. Name and address of person who completed cause of death	(Item 23a) (Type	, Print	R	7			
:	Sta Registr		31. Date filed (Month, Day, Year) 82. Registrar's MAR 2 4 2005	Signature	Es.	,				
			A AN ARLANG	The state of the s						

amend iitem/16a, Type or Print in B/24/y Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2005 Thelma Gambrell MArch 16 4:44  $A^N$ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MOntgomery 01ney Montgomery General Hospital If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex Days Min Months Hours 1925 Winnsboro, 1 □ M 210 F 219-19-5674 Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 10a, State 10h County Yes 2 No Rockville Director Montgomery MD 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 4116 Norbeck Road 20853 USA Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 A No Specify: Specify: Black þ 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Private Owned co-owner Dry Cleaners 4 yrs. <del>System</del> 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Butler Woodward Augusta Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) KAthy Gambrell 4116 Norbeck Rd. Rockville. MD. 20853 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 

Burial 2 □ Cremation 3 □ Removal from State 3-22-05 Fort Lincoln Brentwood, MD. \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Marshall's Funeral Home 21. Signature of Funeral Service Licenses 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4217 9th. St. N.W. Washington, D.C. 20011 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MYOCARDIAL INFARCTION 4 DAWS Due to (or as a consequence of): ARTERY DIJEAJE WEDNARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medicai IF FEMALE: If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live birth 2 Fetal death Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Dav 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 Yes 2 No 3 Probably 4 Unknown ENCEPHALOPATMY Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No № Д 24a. Was an ALZHET MEKS HYPERTEMSION autopsy performed? 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 XNo 2 ER/Outpatient 2 1 X Inpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🔀 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

certificate be executed attending physician and for use as the burial-transit Division of Vital Records, P.O. Box 68760. signed by the at d be detached fo page 2 or Attending Physicien: director, this the funeral After s after death. filled in by Hospital within 24 hours a the

**Funeral** 

Director

?? is marked other than "natural", or items 23a or 28a-f show traumatic avent, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Ite may injury or other traumatic avent, the Medical Evantina and

**Physician** 

/Medical

Examiner

Baltimore, Maryland 21215-0036

with the Maryland

death v

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) MAR 24 2005

29b. Signature and title of certifier

(Check only one)



Dr. Lilvie Heinz - Munchoric

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D005854

29d. Date signed (Month, Day, Year)

MARCH

16, 2005

CPM 05-02054 William Gilbow

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

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1-	For State Registrar

			Registrar			Ce	rtificat	e of L	Jeath			Reg. N	io.		
	Physici	an	1. Decedent's Name (First, Middle						<u></u>		2. Date of De Month		2, 2	Year	3. Time of Death
	/Medic	al.	William Edward				4h Cihi	Toum or	Location	of Dooth	March		c. County	2005	03:46 м
}	Examin	er	4a. Facility Name (If not institution, 420 Wampler Roa	nd			]	Essex				4		imor	e
	Funeral Director		5. Social Security Number 217–68–5743	6. Sex 7 1√2 M 2□ F	Age (In yrs. i	ast birthday Yrs.	Months	1 Year Days	If Under Hours	Min.	8. Date of Bi (Month, Da Dec. 11	а <i>у, Үө</i> а	<sup>0</sup> 55	9. Birthpl Coun Mary	lace (State or Foreign try) land
	and and		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or L	ocation							11	Od. Inside City Limits
	Many -1 sh	tor	Maryland Baltim	ore	Mi	ddle 1	River								1 ☐ Yes 2 🙀 No
	or 28s	Director	10e. Street and Number				10f. Zip	Code				10g. C	Citizen of W	/hat Coun	try?
	ath wi		420 Wampler Roa					21220				U.S.A.			
	items	Funeral	11. Marital Status  1 ☐ Never Married 2 Married	12. Was Decede Armed Force	s?	S.   13	Was Deced	dent of Hi cify Cuba	spanic Or n, Mexicai	igin? (Spe n, Puerto l	cify Yes or No Rican, etc.)	o- 14. Race - American Indian, Black, White, etc.			
920	urs af	by	3 Widowed 4 Divorced	ed 1 Tes 2 If Yes, Give Year or Date	_		1 🗆 Yes	2X No	Specify:				Specify:		ite
2-0	72 ho	Completed	15. Decedent (Specify only highes	's Education		(Giv	edent's Usua e kind of wo	rk done a	lurina mos	at of worki	na	16b.	Kind of Bu		
2	within ne. han	mple	Elementary/Secondary (0-12)	College (1-4d	or 5+)	Labo:	DO NOT u	se retired	)			Co	nstru	ctio	n
7	filed within 72 hours after death with the Maryland Hygiene. other than 'natural', or Items 23a or 28a-f show ant, the Medical Evanta ar must be indiffed at		17. Father's Name (First, Middle, I	Last)		Lauc.	rer		18. Moth	er's Name	(First, Middle				.1
lan	m - 0 2	To Be	Kenneth Cliffor	d Gilbow, s	Sr.				Cath	erine	e Fore				
Maryland 21215-0036	permit. Pages 1 and 2 should be Departiment of Health and Menta Important: If item 27 is marked any injury or other traumatic as <u>pages</u> .		19a. Informant's Name/Relationsh		-						l Route Numb				
≥ ຜົ	l and lealth im 27 har tr		Lisa Gilbow (Wi	fe)	20h B				ad,		more,				
Jore	ages 1 nt of h : If ita		20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation								Location -				
altimore,	artme ortani injury		* 4 □ Donation 5 □ Other (Sp		Бау		2. Name ar	d Addres	s of Facili	ity					_
B	Pen Pen Pen Pen Pen Pen Pen Pen Pen Pen		) Contract				1407 (	Bru Old E	izdzi: laste	nski rn Av	Funera ænue,	l H Ess	ome, ex, M	P.A. Jaryla	and 21221
Е			23a. Part1 Enter the disease, or shock, or heart failure. List	complications that caus only one cause on each	sed the death										Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. ATHE	lasci	EROTI	C	crap	010	MRU	VAR	0	ISER	ISE	Onset and Death
ji.	/Medical Examiner		· · · · · · · · · · · · · · · · · · ·	Due to (or	as a conseq	uence of):									
Ĺ,	*	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or	b										
	ransit	Examiner	that initiated events	с.											
90,	se exe		resulting in death) Last	Due to (or	as a conseq	uence of):									
68760,	physicate I	n/Medical		d											
ŏ	The law requires that the death certificate be executed the has been signed by the attending physician and age 2 should be detached for use as the burial-transit	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor	0	incy	Oc-4i						23d. Date	e of delive	ry
m	a death	Physicla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 □ Pregnan	at time of d	eath 5	□Ectopic pi □ Other (sp	ecify)	······································				Mor	nth	Day Year
P. O.	w requires that the deat been signed by the attr should be detached for	Phy	9 ☐ Unknown Part II. Other significant condition			ulting in the	underhing	auca aive	on in Part		23a Did	tobacco	o usa conti	ibute to th	ne cause of death?
ds,	signe signe	d by	Tal. ii. ottor organicani oottani	out the state of t	, but not rus	anning in the	andonying o	ausu givi	or in the care	••					ably 4 Munknown
Records,	w requ	Completed									24a. Was	an	24b. V	Vere autor	psy findings available
	The law	ошо									auto perf	ormed?	, p	rior to cor leath? XYes	npletion of cause of
Vital	(0 14	0 L									(Check only	опе)			
of <	Physician: this certific ral director.	ြိ	Yes 2□ No	Hospital: 1  Inp	atient 2		-				me 5 ☐ Res				SCENE
on	ding After fune	27. Manner of Death  1 Natural 5 Pendin	Day Year)	28b. Time Injury	or 2	28c. Injury Work	rat ⟨? Yes 2. [[		28d. Describe	now inj	ury occurr	90			
Division	determined 28e. Place of Injury - At home, fa									-				er or Rura	l Route Number,
Ō						Y)					City or To	wii, Sia	10)		
	The set of														
							290	c. License				29d. D	ate signed	(Month,	Day, Year)
	aue D							OC.	ME			Ma	rch 2	22, 2	005
	1		30. Name and address of person	who completed cause of		1 23a) (Type	Print)	1 Pe	nn St	reet	Balt:	imor	ce, M	aryla	nd 21201

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

22. Registrar's Signature

			1 - For State Registrar	S	State of M	larylan	d / Depa		t of H	lealth a	and N	fental Hyg	_	) 5	10017
	Dhysia		1. Decedent's Name (First, Middle, L.	ast)								2. Date of Deat Month	h Day	Year	3. Time of Death
	Physici /Medi		Elmira B. Gross									March 19,		T Oal	4:10 P M
1	Examir	ner	4a. Facility Name (If not institution, gi	ve stre	et and number,	)				Location	of Death		4c. Count	y of Death	
			4102 Rollins Avenue 5. Social Security Number 6.	Sex	7 4	ne (In ure I	ast birthday)	Ba If Under	1timo	re If Under	24 Hre	Data of Righ		NA	
P	Funeral Director				20XF	97 ge (iii yis. ii	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day, 01-21-19)	Year)	9. Birth	olace (State or Foreign
			Usual Residence of Decedent									01-21-190	J0	Mary	land
	larylan ehow	_	10a. State 10b. County			10c. City	, Town or Lo								10d. Inside City Limits
	or 28e-1	Director	MD NA				Bal	timore							1 Yes 2 □ No
	with t	급	10e. Street and Number					10f. Žip				10	Og. Citizen of	What Cou	ntry?
	eath w	era	4102 Rollins Avenue	12	Was Decedent	Ever in 119	12.1	Man Daned	2120		-1-2 (0-			SA	
"	fter d r ften irer	Funeral	1 ☐ Never Married 2 ☐ Married		Armed Forces	?	5.   13. \	f Yes, spec	fy Cuba	n, Mexicar	n, Puerto	ecify Yes or No- Rican, etc.)		ck, White,	can Indian, etc.
036	urs a	by	3 XWidowed 4 □ Divorced		If Yes, Give Year or Dates:			1 ☐ Yes 2	No X	Specify:			Specif	y: Blac	de
5-0	within 72 hours after death with the Maryland ene. then "naturel", or items 23e or 28e-1 ehow is Modical Exemine must be notified at	Completed	15. Decedent's 8 (Specify only highest gr				16a. Deced	ient's Usua	l Occupa	ation	t of work	ina 1	6b. Kind of B		
2	within ene. then "	nple	Elementary/Secondary (0-12)		College (1-4or	5+)		kind of wor DO NOT us	e retired,	)	i or work	ing	_		
2	be filed within 72 hours after death with the Maryla hat Hygiene. sd other then "naturel", or items 23e or 28e-1 ehon event, if e Mailcal Exercifier must be natified a		8 17. Father's Name (First, Middle, Las	H)			Home	maker		40.14-11				omesti	.c
Maryland 21215-0036	d be f antal h	Be C		)						18. Mothe		(First, Middle, M		ne)	
<u> </u>	s 1 and 2 should be f f Health and Mental I item 27 is marked or other treumetic eve	J.	Edgar Brogden  19a. Informant's Name/Relationship	Туре.	Print)		19b Mailin	a Address	(Street a	and Numbe		Marie Emon		State 7in	(Code)
	12 g		Cynthia L. Green / Day									, MD 21213		State, ZIL	7 0000)
Baltimore,	s 1 and 3 of Health item 27 other tr		20a. Method of Disposition			20b. Pla	ace of Dispo	sition (Nam	e of		W-166		Oc. Location	City or To	own, State
E	Page nent o int: If iry or		1 X Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Speci	]Remo fy)	oval from State		yland N	-		1	03-25	i-05 ⊤	aurel	Morul o	nd
ati	permit. Pages Department of I Importent: If ite any injury or of		21. Signature of Funeral Service Lice	nsee		,		. Name and		- 2		03 1	aurer, 1	. Kil y Lo	IIG
<u> </u>	89 5 2 8	l lb	Chimerla U	ene			Wy	lie Fur	neral	Home	638 N	. Gilmor S	St. Balte	o, MD	21217
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	olicati one c	ons that caused ause on each li	d the death. ne.	. Do not ente	er the mode	of dying	g, such as	cardiac o	or respiratory arre	st,		Approximate Interval Between
3	Physician		Immediate Cause (Final disease or condition	а.	Mir	tem.	X	1019	5-7-	35					Onset and Death
	/Medical Examiner		resulting in death)		Due to (or as										
17.		-	Sequentially list conditions,	b	Due to (or as		CLEDO	nc	CV	2016	Meu	with In	SEVEE		
V	ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury		Due to (or as	a conseque	erice or).								
,	execu n and ial-tra	Examiner	that initiated events resulting in death) Last	c	Due to (or as	a conseque	ence of):								
8760,	rate be executed whysician and the burial-transit	call	· ·	d											
9	rtifical ng phy as th	ed	In Court of												
Box	he death certificate be executed the attending physician and hed for use as the burial-transit	Physician/M	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 ♥ No		If yes, outcome 1□Live birth 4□Pregnant at 9□ Unknown	2 Fetal	death 3 🗌	Ectopic pre Other (spe					23d. Da Mo	te of delive nth	ory Day Year
P.O.	ac oc	Phy	9 Unknown												
	ires that signed b	by	Part II. Other significant conditions	ontribi	uting to death b	ut not resul	ting in the un	derlying ca	use give	n in Part I.					e cause of death?
O.C.	w requir	eted	11970 1119 101815									1 L Yes	2 🗆 No	3 Prob	abty 4 Tunknown
Vital Records,		Completed	HUBEDICACION									24a. Was an autopsy		prior to cor	osy findings available npletion of cause of
a	iclen: The certificate harector, page											performe 1 ☐ Yes 2	ONo I	death?	2□ No
		o Be	25. Was case referred to medical examiner?  1 ☐ Yes ♣☑ No	Hosp	ital:		7.0	-7	Other			(Check only one,			
of	y Phys er this eral di	-	27. Manner of Death	2	8a. Date of Inju- (Month, Date)		R/Outpatient 28b. Time of		c. Injury Work	4 ∐ Nur at	rsing Hor	ne Residen	ce 6 Oth	er <i>(Specif</i> ) ed	")
Division	Attending I r death. ector: After by the funer	atlo	Pal Natural 5 ☐ Pending 2 ☐ Accident investigation		(Month, Da)	y Year)	Injury	М		? es 2 □ N			, , , , , , , , , , , , , , , , , , , ,		
Vis	I or Attendi after death Director: A in by the fe	tific	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	9 2	8e. Place of Inju	ury - At hom	ne, farm, stre	et, factory,	office		2	28f. Location (Stre		er or Rura	l Route Number,
ō	rs after al Dir	Certification:			building, etc	с. (Зреспу)						City or Town,	State)		
	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	niner:	n: To the best of On the basis of and manner sta	examination	ledge, death on and/or inv	occurred at estigation, i	t the time	e, date and inion, deat	i place, a	and due to the cau and at the time, dat	ise(s) and ma e and place, a	nner as st and due to	ated. the cause(s)
	To the within To the comple	Σ	29b Signature and title of certifier						License			290	d. Date signed	(Month, I	Day, Year)
}			V frut 111.			>			DZI	3000			3144	701	
	2		30. Name and address of person who	comple	eted cause of d	eath (Item 2	23a) (Type, F				_		1		
			21 Data Glad (Marth Day Your	2	M/l		ws ma	won	18	WX	R	ray. W	1 3	15-3	0
	Sta Registra	te ar	31. Date filed (Month, Day, Year) MAR 2 4 2	005	32 Registra	ars Signatu	re L	ASD.							
DHA	/H 17 Rev 1/20		X		- The same	- /	1								

			1 - For State Registrar		State	of Maryla		artment of I rtificate of		Mental Hy	giene Reg. No.	005	10018
			Decedent's Name (First)	, Middle, La	ist)					2. Date of De		.,	3. Time of Death
	Physici /Media		Bobbie	F	louston					Month	Day 2.1	Year 2005	4:00 A M
	Examir		4a. Facility Name (If not in	stitution, giv	e street and nu	ımber)		4b. City, Town, o	or Location of Dea			ounty of Death	1100 11
1			Prince Geo	rapic	Hoenit	- 21		Cheve	rlv		Pr	ince Ge	orges
	Funeral		5. Social Security Number		Sex		rs. last birthday)	If Under 1 Year			rth	9. Birth	place (State or Foreign
	Director		256 24 2200		1 ☐ M 2 🙀 F	80	Yrs.	Months Days	Hours Mi	n. (Month, Da	1925	Cou	okin, GA.
			256-34-3308 Usual Residence of Deced	dent		- 00				Jan /	1323	Litting	JAZII, OII
	iand		10a. State 10b.	County		10c.	City, Town or Lo	cation					10d. Inside City Limits
	Mary	Ö	MD Pri	nce (	Georges		Laure1						Maria Yes 2 No
	288 288	Director	10e. Street and Number					10f. Zip Code			10a Citiza	en of What Cou	ntn/?
	with pa or	₫							•		Tog. Citiza		nuyr
	72 hours after death with the Maryland natural', or Hems 23a or 28a-f show lical Exterit withtel by Inditied at	Funeral	12200 Barcl	Lay Pi		-4	110	2070				USA	
	er de	Š	11. Marital Status	- · · · ·	Armed F		10.5.	Mas Decedent of F f Yes, specify Cub	tispanic Origin? ( an, Mexican, Pue	(Specify Yes or No orto Rican, etc.)	)- 14	<ol> <li>Race - American Black, White,</li> </ol>	
36	or or	by F	1 ☐ Never Married 2   3 ☑ Widowed 4 ☐ Di		If Yes, G	2 X No ive		I□Yes 212 No	Specify:		ي أ	Specify: Bla	ck
8	ural	d d			Year or [	Jates:						, , ,	
5	nat IIc	Completed		ecedent's E highest gr	ducation ade <i>completed)</i>	)	(Give	dent's Usual Occup kind of work done	during most of w	orking	16b. Kind	d of Business/In	dustry
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2	e filed within al Hygiene. other than ' vent, the Ma	ပိ	12th.				ECO	nomist			-	Gover	nment
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<u>ya</u>	should be I and Mental I s marked of umatic eve	2	William Fla	anagar	1				MArjo	rie Humb	er		
Maryland 21215-0036			19a. Informant's Name/Re Valorie Gai			ah+a				Rural Route Numb			Code)
ø)	1 and 2 Health tem 27 l		20a. Method of Disposition		ILIO / Da		D. Place of Dispo	sition (Name of	nue, Tak	oma Park		20912 ation - City or To	own State
Baltimore,	permit. Pages of Department of Himportant: If ite any injury or ot once.		1 ⊠Burial 2 □ Crem			State	cemetery, cren	natory or other pla				_	, olato
ij	tmer tant tant		`4 □Donation 5 □ O			r		Nationa	1	5-05		el, MD.	
3al	permi Depar Impor any ir		21. Signature of Funeral S	iervice Lice	1 1/2					rshall's			
_	<u></u>		XIM	and	rall					koma PAr		. 20912	
			23a. Part Enter the dise	ase, or come. List only	plications that	caused the d	eath. Do not ent	er the mode of dyir	ng, such as cardi	ac or respiratory a	rrest,	1000.00	Approximate Interval Between
	Physician		Immediate Cause (Final	,	1	1.1150	VO D	55 <b>~</b> 055	1001.0	and the same			Onset and Death
	/Medical		disease or condition resulting in death)	-	a	(or as a cone	sequence of	aw	Metash	210			
	Examiner				54010	(01 43 4 0011	sequence on,						
		ā	Sequentially list conditions if any, leading to immediate	i.	b. Due to	(or as a cons	sequence of):						
J	ted	Examiner	Cause (Disease or injury	1									
V	and I-tra	xar	that initiated events resulting in death) Last		c. Due to	(or as a cons	equence of):						
58760,	icate be executed physician and s the burial-transit	E			000.0	(01 45 4 55115	10quanios 01).						
87	ohysi the t	dlcal			d								
		ш.	IF FEMALE:										
Вох	if the death certif by the attending tached for use as	Physician/M	23b. Was decedent pregn.		23c. If yes, ou 1 ☐ Live I	tcome of pre-		Ectopic pregnancy	,		23	d. Date of delive	*
Э.	dea ne at sed fo	<u>C</u>	in the past 12 months 1 ☐ Yes 2 ☐ No	57		nant at time o		Other (specify) _				Month	Day Year
0.	t the by th	hys	9 🗌 Unknown		9□ Onkn	iown							
·.	or Attending Physician: The law requires that the death certif ter death. Iter death control the death certified the strength of the this certificate has been signed by the attending in by the tune at director, page 2 should be detached for use a	by P	Part II. Other significant c	onditions	contributing to d	leath but not	resulting in the ur	nderlying cause giv	en in Part I.	23e. Did t	obacco use	contribute to the	ne cause of death?
ő	quire n sig	D D	Demen	79						1 🗆	Yes 21	/ No 3 ☐ Prob	ably 4 Unknown
Ö	w require been sli should b	Completed	-		A 1 .					040 1450		0.45 14/000 014-	and findings available
ě	has has	m	Express	VE	Apna,	s i a				24a. Was	DSV	prior to col death?	psy findings available mpletion of cause of
=	: The I	ပ္ပ	•							1 ☐ Yes	rmed? 2 ☑ No	1 Yes	2 No
Vital Records,	ysician: Th is certificate director, pag	Be	25. Was case referred to n examiner?	nedical						eath Check onl	one		
-	hysi his c	0	1 ☐ Yes 2 ፫ No		Hospital: 1 🗗	Inpatient 2	☐ ER/Outpatien	1 3□ DOA Oth	er: 4 🗆 Nursing	Home 5 Resi	dence 6 (	☐Other (Specif	y)
0	ding Phy h. After thi funeral o	Ë.	27. Mann Death	Donding	28a. Date	of Injury th, Day Year	28b. Time of Injury	28c. Injur Wor	y at	28d. Describe	how injury	occurred	
ō	ath. r: Al	atic		Pending investigatio					Yes 2 □ No				
Division of	or Attence fter death Director: in by the	ertification:		Could not b	286. Place	of Injury - A	t home, farm, stre	eet, factory, office		28f. Location (	Street and	Number or Rura	I Route Number,
	or A fter Direction by	ient Ten	4   Horridge		build	ing, etc. (Spe	ecity)			City or To	wn, State)		
	splt	aC	29a. Certifier	ertifyina Ph	ysician: To the	e best of my l	nowledge death	occurred at the tir	ne, date and place	e, and due to the	caucolo) o	nd manner on a	tated
)	To the Hospitel of within 24 hours of To the Funeral D completely filled in	edical	(Check only 2 Moone)	edical Exar	niner: On the b	easis of examiner stated.	ination and/or inv	estigation, in my o	pinion, death occ	curred at the time,	date and p	lace, and due to	the cause(s)
	o th	Me	29b. Signature and title of	certifier	und man	Julian.		29c, Licens	e number		29d Date	signed (Month,	Day Yeart
	⊢ ≯ ⊢ ŏ		<b>N</b> (1 1	1. O	2								
			Wala	KU.		v2ing	1	1700	20781	0	2/2	, ~ )	
	3		30. Name and address of p	erson who			tem 23a) (Type, I	Print)		c. 7-	105 /	contantan	lt MO 20776
			Chalak	0 -	Bevz	ingi	. 75	00 literio	ier parki	vay suit	co) (	MICH DE	11 1110 2011C
	Sta		31. Date filed (Month, Day,		2007	Registrar's Sig	nature			V			
	Registr	ar	MAR	2 1 20	05 Aca	2.12 .	Al. Som	100					

			1 - For State Registrar	State of M	/larylan		rtmen <i>tificat</i>			and M	lental Hy	giene	nns	10019		
£.	Physici	ian	1. Decedent's Name (First, Middle  Katherine	s, Last) Schultz	,	н	elm				2. Date of Do		2005 Year	3. Time of Death  11:14a M		
	/Medi Examir		4a. Facility Name (If not institution					Town, or	Location of	of Death	Haten	4c. County of Death				
£ 5	Lxqiiii	,	St. Agnes Hosp	ital			Ba1	timo	re			N	/A			
Ì.	Funeral Director		5. Social Security Number 214-40-4015	6. Sex 7. A 1  M 2  F	92	ast birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, Di 4-10-	rth 1912	9. Birth PA	pplace (State or Foreign untry)		
	yland Iow		Usual Residence of Decedent  10a. State 10b. County		10c. City	y, Town or Lo	cation							10d. Inside City Limits		
	a-fsh	ctor	MD Baltim	ore	Ca	tonsvi	11e							1 ☐ Yes ¾Ã No		
	with the	Director	10e. Street and Number				10f. Zip	Code				10g. Citi	zen of What Cou	untry?		
	eath v	Funeral	709 Maiden Choi	ce Ln.	at Ever in II	S 112 1		228	anania Ori	ain? (Spe	ody Voc or N		USA 14. Race - Ameri	iono Indian		
9	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. I Health and Mental Hygiene. I ferm 27 Is marked other then "naturel", or Items 23s or 28e-f show other treumatic event. The Medical Exam and the conflight at	Fun	1 Never Married 2 Mar	Armed Forces	S? No WWI	I '	Yes, spec		Specify:		cify Yes or No Rican, etc.)		Black, White			
21215-0036	urel',	d by	3 Widowed 4 □ Divorced	Year or Dates	;					WILLE						
15-	in 72 n "nat	Completed	(Specify only highe	t's Education st grade completed)		16a. Deced (Give life. L	lent's Usua kind of wor DO NOT us	k done d	urina mos	t of worki	ng	16b. Ki	nd of Business/Ir	ndustry		
212	d with giene.	mo	Elementary/Secondary (0-12)	3 College (1-4o	r 5+)	Nurse						US A	rmy and	School		
Maryland	2 should be filed withing and Mental Hygiene.  Is marked other then eumatic event, the	Be	17. Father's Name (First, Middle,	Last)					18. Mothe	r's Name	(First, Middle	, Maiden	Sumame)			
ryla	d Mer marke	J.	Harry A. Schul  19a. Informant's Name/Relations			10h Mailio	a Addross	(Stroot o			irden	ar Citur	r Town, State, Zi	- 0- 4-1		
$\geq$	1 and 2 s Health an tem 27 Is		Kathleen A. He		r								ryland 2			
altimore,	0 0		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation		20b. P	lace of Dispo emetery, cren	sition (Nan	ne of ther place	)		ate		cation - City or T			
ţi	permit. Pages Department of I Importent: If it Iny injury or o		' 4 □ Donation 5 □ Other (S	pecify)		don Par	ck Ce	mete	ry	larch	22, 0	5 Bal	ltimore	City		
Bal	permit. Pag Department Importent: any injury conce.		21. Signatur of Funeral Service	Licensee	מנוח	, 22	. Name an	d Addres	s of Facilit	y Lou	don Pa	rk Fu	ineral H	lome		
	- %		22. Name and Address of Facility Loudon Park Funeral Hom  3620 Wilkens Ave. Baltimore, Maryland 21  36a. Paryl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.													
	Physician		Immediate Cause (Final disease or condition	only one cause on each		10 00	rdi	al	ZN					Interval Between Onset and Death		
	/Medical Examiner		resulting in death)	Due to (or a	ıs a consequ	9		<del></del>						0(17)		
h	- Adminici	Ē	Sequentially list conditions,	b. Due to for a	ıs a consequ	ience of):										
V	outed id ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	С.												
. 00	be executed sician and burial-transit		resulting in death) Last	Due to (or a	is a consequ	ience of):										
68760,	icate b physic s the b	dlca		d												
Вох (	death certificate be executed e attending physician and of for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom								2	3d. Date of deliv	ery		
O. B	e deatl he atte	sicia	in the past 18 months?  1 Yes 2 No	1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown			Ectopic pre Other (spe		<u>.</u>				Month	Day Year		
٥	that the de sed by the a detached f		9 ☐ Unknown*  Part II. Other significant conditions		but not resu	ulting in the ur	derlying ca	avisa diva	n in Part I		23a Did t	obacco u	se contribute to t	he cause of death?		
of Vital Records,	law requires that as been signed by 2 should be deta	ed by									1 🗆			bably 4 Unknown		
eco	ne law re has bee ge 2 sho	ompleted									24a. Was		24b. Were auto	opsy findings available ompletion of cause of		
a B	ate pag	Соп					_				perfo	rmed?	death? 1 ☐ Yes	2□ No		
Vita	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2⊠ No	Hospital:	× 201	ED/O		Othe	r		(Check only o					
To be a seried of the seried o									fy)							
sior	Attending Phradestrians of the funeral by the funeral	catio	Accident 5 Pendin investig	jation	ay 16a1)	Injury	М		es 2 🗆 l	No						
27. Manner of Death  Volume  V								and Number or Rural Route Number, ate)								
	To the Hospitel or Atta within 24 hours after de To the Funerel Directa completely filled in by th	edical C	29a. Certifier (Check only one)  Certifyin 2 Medical	g Physician: To the bes Examiner: On the basis and manners	of examinat	wledge, death ion and/or inv	occurred a estigation.	at the time in my opi	e, date and inion, deat	place, a	and due to the ed at the time,	cause(s) date and	and manner as s place, and due to	stated. the cause(s)		
	To the within 2. To the complet	Σ	29b. Signature and title of certifier					License					signed (Month,			
•				- (mn				47	47	/		10/46	sh 51	5007		
	10		Had Co	who completed cause of	rend	1 Cho		(9	ng	(o	tens	111/4	2 May 21,	yu.		
8	Sta Registr		31. Date filed (Month, Day, Year)  MAR 2	1 2005 32. Hegis	trar's Signat	ure K Ao	side!									

#### amend item#9, per H, G841, 3/24/05 TT State of Maryland / Department of Health and Mental Hygiene () 5 or State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** 1:14p M 21 HUDSON MARCH MAR GARET 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Columbia Howard Howard County General Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Sex 1 □ M 2 X F Days Canada Yrs 370.32.0247 August 14, 1921 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. Count 1 ☐ Yes 2 No Ellicott City Maryland Howard Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21043 Canada 3004 North Ridge Road: Apt. 105 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Never Married 2 Married 2 No Specify: þ 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerical Secretary 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Archibald Beamish Olga Robinson 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5196 Talbots Landing Ellicott City, Maryland 21043 Ms. Anne Hudson Scalio Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State \* 4 Donation 5 Dother (Specify) 03/22/2005 Baltimore, MD Bayview Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 3 DAYS MASTROINTESTIMAL Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Year Month Day Part contribute to the cause of death? by

**Physician** /Medical **Examiner** 

injury or

any.

**Funeral** 

Director

or Itams 23a or 28a-f show

"natural",

marked other than

permit. Pages 1 and 2 should be Department of Health and Mental Important: If itam 27 is marked o

the Medical Examiner must be notified at

death with the Maryland

filed within 72 hours after

Baltimore, Maryland 21215-0036

signed by

has

After this

within 24 hours after death To the Funeral Director:

physician and s the burial-transit as detached page 2 should

Be Completed

Certification: To

Medical

25.

27.

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 □Live birth 2 □ Feta 4 □ Pregnant at time of c 9 □ Unknown				Month Day Year
II. Other significant conditions c	ontributing to death but not res	sulting in the underlying	cause given in Part I.	23e. Did tobacco u	se contribute to the cause of death?
RENAL FAIL	-urë			1 ☐ Yes 2	No 3 Probably 4 Unknown
	W1			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 \( \text{Yes} \) 2 \( \text{No} \) No
Was case referred to medical			26. Place of De	ath (Check only one)	
examiner? 1 □ Yes 2 → No	Hospital: 1 Impatient 2	]ER/Outpatient 3□ E	OOA Other: 4 Nursing	Home 5 Residence €	S □Other (Specify)
Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injur	y occurred
3 Suicide 6 Could not be 4 Homicide determined			ory, office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number, )
. Certifier 1 Certifying Ph	ysicien: To the best of my kno	owledge, death occurre	d at the time, date and place	e, and due to the cause(s)	and manner as stated.

30. Name and 9

State

Registra

JON ATHAN F15H 31. Date filed (Month, Day, Year)

(Check only

one)

29b. Signature

MAR 2 4 2005

MO



ess of person who completed cause of death (Item 23a) (Type, Print)

#200 Counsia

29d. Date signed (Month, Day, Year)

MARCH

21,2005

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D5 1960

			For (	State of Maryland /						ental Hv	riene	,	
			1 - For State Registrar			rtificat					Reg. No.	2005-	10021
ï	Physici	an	Decedent's Name (First, Middle, Last)							2. Date of Dea Month		20 (Year)	3 Time of Death 9:30 A M
	/Medic	cal	Lawrence 4a. Facility Name (If not institution, give str	Jackson S	r.	4h City	Town or	Location of	of Death	MArch 1	8,	2005 County of Death	9:30 A M
	Examir	ıer	Manor Care	di ang ngmbory		, ,		Spri				ontgomer	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last		If Under Months	1 Year	If Under Hours		8. Date of Birt (Month, Day	h	9. Birthp	y lace (State or Foreign atry)
	Director		Usual Residence of Decedent	91	Yrs.							, 1913 Y	/irginia
	yland		10a. State 10b. County	10c. City, To									0d. Inside City Limits
	Ba-1 s	Director	MD Montgomen	y Silv	ver (	Sprin	g						1 ☑ Yes 2 ☐ No
	with the	Dire	10e. Street and Number 2201 Colston Drive	#208		10f. Zip	Code 209	10			10g. Citi	izen of What Cour USA	itry?
	death rms 23	Funeral		Was Decedent Ever in U.S.	13.	Was Deced			gin? (Spe	cify Yes or No- Rican, etc.)		14. Race - Americ	an Indian,
36	or ita	y Fui	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give	- 1	If Yes, spec 1 ☐ Yes :			i, Puerto	Rican, etc.)		Black, White, Specify: B1a	
21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. id othar than "natural", or itams 23a or 28a-1 show evant. I're Medical Examirar must be nuitled at	ed by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Educa	Year or Dates:		dent's Usua					16h V	nd of Business/Inc	
215	hin 72 8. 8n "na Medic	plet	(Specify only highest grade of Elementary/Secondary (0-12)		(Give	kind of wor DO NOT us	rk done d	furina most	t of workii	ng	IOD. N	nd of Business/inc	dustry
2	e filed wit al Hygiene othar the vant, Ire	Completed			Educa	ator						• County	Schools
Maryland	t be fill had ad other	Be	17. Father's Name (First, Middle, Last)  JAmes JAckson							(First, Middle,	Maiden	Sumame)	
aryl	2 should by and Menta is markad sumatic ev	To	19a. Informant's Name/Relationship (Type	Print) 19	9b. Mailir	ng Address	(Street a	Elm and Numbe		ihoite  Route Numbe	r, City o	r Town, State, Zip	Code)
	27 = 27 = 1		LAwrence JAckson,	Jr.	220	Brigh	htlea	a Dri		anham,			
Baltimore,	ges 1 au it of Hea if itam or othe		20a. Method of Disposition 1  → Buriai 2 □ Cremation 3 □ Ren	20b. Place ceme.	of Dispo tery, cren	natory or o	ne of ther place	9)	D	ate	20c. Lo	cation - City or To	wn, State
III.	t. Pa rtmer rtant		<ul> <li>4 □ Donation 5 □ Other (Specify)</li> <li>21. Signature of Funeral Service Licensee</li> </ul>	Linco								land, MD	
Ba	Depa Impo any is		O P mauha	ll								neral Hom n, D.C. 2	
			23a. Parti Enter the disease, or complica shock, or heart failure. List only one	ions that caused the death. Deause on each line.								., 5.0. 2	Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition resulting in death)	Pneum	on	ia.							Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence	e of):								
4		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence	e of):								
V	ecuted and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	B /									
8760,	To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funaria after death.  To the Funaria Inerctor: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	ical E		Due to (or as a consequenc	e or):								
မှ	tificate ig phys as the		d							-			
Вох	eath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea	th 3 [	Ectopic pro	egnancy	^/	10		2	23d. Date of deliver	,
P.O.	that the deaned by the a	Physician/Med	1 Yes 2 No	4☐ Pregnant at time of death 9☐ Unknown	5	Other (sp	ecify)	14	114			Month	Day Year
	igned by be deta	by Ph	Part II. Other significant conditions contril	outing to death but not resulting	in the ur	nderlying ca	ause give	n in Part I.		23e. Did to	bacco u	se contribute to the	e cause of death?
ords	w require been sig should b	ted k	Electrolyle	Imbalo	24C	C				1 🗆 Y	es 2	ZANo 3 ☐ Proba	ably 4 DUnknown
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	10		30. Name and address of person who comp	Y STREET	11	nou	NT	RA	INI	ER. r	ni	207	12
	Sta Registra		31. Date filed (Month, Day, Year)	32. Registrar's Signature		- da							
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DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Month Day Year VOHNSON CLARA MARCH 20 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** If Under 1 Year If Under 24 Hrs. 8. Da CENTER HERRICHL BALLINGAR KintHOUEST 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 Md Date of Birth (Month, Day, Year) **Funeral** 1□M XXF Days Months Hours 220-14-7807 89 Yrs. Md Director 10-15-1915 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 17 Is marked other than "natural" or Itams 23a or 28a-f show traumatic event, If a Medical Examiner must be notified at 10d. Inside City Limits 1 Yes 2 No Director Balto Pikesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3720 Parkfield Road 21208 USA death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itar any injury or other traumatic event, the Medical Examinat Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No þ Specify: **Black** 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 8th grade Private Duty College (1-4or 5+) N/ACook 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry Chase Martha Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Milford Van Johnson - Son 3720 Parkfield Road Pikesville, Md 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Md Nat Memorial Park 3-24-2005 Laurel, Md <sup>1</sup> 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H Wabash Avenue Balto, Md 21215 almon 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Anterioselepetic CANDIOVASEALAN DISEASE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine signed by the attending physician and d be detached for use as the burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 DEctopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) Records, P.O. 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ANDXIC ENCEPHALCHATTHY SECONDANY TO CHUIC RESPIRATORY 1 Yes 2 No 3 Probably 4 Donknown Completed Annest CHILDRIC RENAL Faihor PERIPHENTE Was an Diles 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed STATUS DEST RIGHT BELOW KNEE AND LEFT ABOVE KNEE AMOUTER 10 YES Division of Vital 1 Yes 2 1 NO 2 1 No Hospital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 1 Impatient 2 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 Natural 5 Pendina within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) ro the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) 0 19502 MARCH 20, 2865 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MERTALWEST HOSPITAL CENTER B. CONTIVAN ORGANDO 31. Date filod (Month, Day, Year) 32. Registrar's Signature Glown 18 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Year **Physician** 9:58 AM ELLER EIIEN 05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hart Hertitage Estate Street Harford If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 💢 F 76 217-24-5735 MD. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits t of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, It a Modical Examinal must be notified at 1 Yes 2 No Funeral Director MD. Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6821 Roberts Avenue 21222 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry during most of working Elementary/Secondary (0-12) College (1-4or 5+) 12 years **Housewife** Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event QNCB. William McCadden Ellen Rogers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Toni Shaw daughter 8221 Peach Orchard Road, Dundalk, MD. 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) March 26, 20a. Method of Disposition 20c. Location - City or Town, State X Burial 2 ☐ Cremation 3 ☐ Removal from State Cardens of Faith Cemetery \* 4 □ Donation 5 □ Other (Specify) 2005 Rosedale, MD. 21. Signature of Funeral Service Licensee Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 23a. Part 1. Enter the disease, or complications that caused the teath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, leave leading to the classical cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 ⊌bnknown 1 ☐ Yes 2 ☐ No Were autopsy findings available prior to completion of cause of death?
 □ Yes 2 □ No 24a. Was an autopsy 2 No this certificate 1 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certification: To 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? within 24 hours after death. To the Funeral Director: After 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number **D-28097** 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier rson who completed cause of death (Item 23a) (Type, Pri 31. Date filed (Month, Day, Year) 32. Agistrar's Signature State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

DH HARON LOMAN 5-181

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black-Indelible Ink. Ensure All-Copies Are Legible

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Physician Medical Examiner  Physician Medical Examiner    December   Leverne   Leverne	2. Date of Death 3. Time of Death	Cen		State	1- S				
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Section   Sect		. last birthday)	7. Age (In yr	ocial Security Number 6. Sex		Funeral			
Top   State   Top   To	Yrs. Nov.27,1924 Pennsylvania	O Yrs.	M <sup>2</sup> ₩ F 8	04–18–0934	204				
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Physician //Medical Examiner    Immediate Cadse (Final disease or condition resulting in death)   FEMALE: 23b. Was decedent pregnant in the past 12 months?   1   Yes 2   No 9   Unknown   2   Yes 2   No 9   Unknown   2   Yes 2   Yes 2   Yes 2   Yes 3   Yes 3   Yes 3   Yes 3   Yes 4   Yes 4			cations that caused the de	o De Esperi	220	40340			
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    23e. Did tobacco use contributions of the part II.   23e. Did tobacco	ath 5 ☐ Other (specify)	death 5		1 ☐ Yes 2 ☐ No	sici	the al	O. E		
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	autopsy prior to completion of cause of performed? death?				g	has ge 2	Rec		
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25. Was case referred to medical examiner?  1	Ditter	TER/Outpatient	lospital: 1   Inpatient 2	examiner?	O 1	/sicie s cert	>		
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U		injury	(Month, Day 7 car)		o te	ath. r: Aft	io		
28f. Location (Street and Number of building, etc. (Specify)  28f. Location (Street and Number of building, etc. (Specify)  28f. Location (Street and Number of building, etc. (Specify)	ne, farm, street, factory, office  28f. Location (Street and Number or Rural Route Number, City or Town, State)	27. Manna of Death 1 Natural 2   Accident   3   Suicide   4   Homicide   5   Pending investigation   3   Suicide   4   Homicide   4   Homicide   5   Pending investigation   5   Pending investigation   6   Could not be determined   28a. Date of Injury   28b. Time of Injury   28c. Injury at Work?   1   Yes   2   No   28c. Injury at   28c. Injury							
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29a. Certifier  1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner of the cause	rledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  on and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)	nowledge, death nation and/or inv	nar: On the basis of exami	(Check only 2 Madical Exami	edical edical	Hosp 24 hou Funa tely fi			
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Raymond Zallingen MS 4924 Ennighell Bbd Balkind	29c. License number 29d. Date signed (Month, Day, Year) 3 23 OS 23a) (Type, Print) 1924 Enryhell Bbd Boll Md 21234		ngon MJ	1 7.11	30. N	12			
D59359 3/23	29c. License number 29d. Date signed (Month, Day, Year) 3 23 OS 23a) (Type, Print) 1924 Enryhell Bbd Boll Md 21234		ngon MJ	Raymond Zoll. Date filed (Month, Day, Year)	ite 31. D				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] 5 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year ALBERT G. LEWIS III 0358 AM 03 22 /Medical 4a. Facility Name (If not institution, give street and number) 4h City Town or Location of Death 4c. County of Death Examiner BALTIMORE UNIVERSITY OF MATMILAND HOSPITAL 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1₩ 2□ F Days Hours Director 215-56-1087 Aug. 22, 1952 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location or Items 23a or 28a-f show 10d. Inside City Limits the Madical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Harford Havre De Grace 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 332 Lewis Street 21078 Pages 1 and 2 should be filed within 72 hours after death inent of Health and Mentat Hygiene. U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1XYes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Unk. 1 ☐ Yes 2X No Specify. þ Specify: 3 Widowed 4 Divorced "natural", White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Railroad Truck Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Albert George Lewis Norma Nelson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a If item 27 is or other tra Norma Lewis (Mother) 1023 Foxwood Lane, Baltimore, Maryalnd 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. Parkwood Cemetery 03/25/2005 Baltimore, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundat Salvice Ricensee 22. Name and Address of Faqility
Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or peart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Qause (Final disease or condition resulting in death) Physician metastatic lung cancer /Medical Due to (or as a consequence **Examiner** Seque is list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for Month Day 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes ②

No this certificate Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check only one) Hospital: 0 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No 1 Tyes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After s after dea. 1 Natural 2 Accident 5 Pending investigation 1 □ Yes 2 □ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral D †S Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P17668 22/05 1801 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 SOUTH GIVEFUE ST BALTIMONEMD 21201 CHTVYM

Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)



			1 - For State o	of Maryland / Depa Cea	artment of Herificate of L		ntal Hygie	211115	10027
	Physici	an	Decedent's Name (First, Middle, Last)			2	Date of Death	Day Year	3. Time of Death
	/Medic Examin	al	4a. Facility Name (If not institution, give street and nur	mber)	4b. City, Town, or	Location of Death	march	4c County of Death	18 H
			5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.   8	. Date of Birth	9 Birth	Olace (State or Foreign
l.	Funeral Director		216-22-3434 1□M 2XF	76 Yrs.	Months Days	Decembe	Month, Day, Ye	928 Mary	ntrv)
	yland now		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo					10d. Inside City Limits
	he Mar 28a-f sl	Director	Maryland Baltimore	Randallst	OWn		100	. Citizen of What Cou	1 ☐ Yes 2 X No
	th with 23a or 3	al Dir	8818 Winterbrook Court			21133		nited Stat	,
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 ie marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. Its Medical Examinal must be notified at once.	by Funeral	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Deck Armed For 1 Yes, Girl Yes,	orces? 2X No ve	Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 ☐XNo	spanic Origin? (Speci n, Mexican, Puerto Ri Specify:	ty Yes or No- can, etc.)	Specify:	
15-0	"natur	leted	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupa kind of work done d DO NOT use retired)	luring most of working	168	b. Kind of Business/In	dustry
212	d withii giene. er than	Completed	Elementary/Secondary (0-12) College (1)	1-4or 5+)	preneur			Shoe Repai	r
Maryland 21215-0036	ould be file Mental Hy varked oth	To Be (	17. Father's Name (First, Middle, Last) James Chester Small			18. Mother's Name (	First, Middle, Mai larsha11	iden Surname)	
Mar	d 2 sho th and t7 le m		19a. Informant's Name/Relationship (Type, Print)  Ms Frances Lee (GrandD					ity or Town, State, Zij Mill, MD	
Baltimore,	Pages 1 and 2 nent of Health a int: If item 27 le iry or other trau		20a. Method of Disposition  1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from  '4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispo	osition (Name of	Da <sup>(</sup>	200	c. Location - City or T	
Balti	permit. Departm Importa any inju		21. Signature of Funeral Service Licensee					Funeral D wn, MD2113	irectors,In 3-4784
			23a. Part. Enter the disease, or complications that shock, or heart failure. List only one cause on	used the death. Do not enter	ter the mode of dying	2		. ^	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  Due to	(or as a consequence of):	eretic	( aloun	uscul	on Descon	es.
	Examiner	<u></u>	Sequentially list conditions, b. Due to	(or as a consequence of):					
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8760,	cate be executed bhysician and the burial-transit	al Ex	resulting in death) Last Due to	(or as a consequence of):					
9	rtificate ng phys	Medical	IF FEMALE:						
.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by Physician/Me	23b. Was decedent pregnant in the past 12 months?	nant at time of death 5	Ectopic pregnancy Other (specify)			23d. Date of deliv Month	ery Day Year
۵.	w requires that been signed b should be deta		Part II. Other significant conditions contributing to d	eath but not resulting in the u	underlying cause give	en in Part I.		co use contribute to t	
al Records,	: The law recate has be page 2 sh	Completed					24a. Was an autopsy performer 1 Yes 2	prior to co	ppsy findings available impletion of cause of
Vital	Phyeician: The this certificate har ral director, page	To Be	25. Was case referred to medical examiner?  1 Yes 2 No Hospital:	Inpatient 2 XER/Outpatier	nt 3 DOA Othe	26. Place of Death (		e 6 Other (Specia	(v)
on of	Attending Phyer death.			of Injury 28b. Time o Injury	of 28c. Injury Work	at 28	d. Describe how		,,
Division of	al or Atter s after dea I Director d in by the	Certification:	3 Suicide 6 Could not be	e of Injury - At home, farm, string, etc. (Specify)	reet, factory, office	28	f. Location (Stree City or Town, S	t and Number or Run State)	al Route Number,
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director; After completely filled in by the funer	Medical C	29a. Certifier (Check only one)  Certifying Physician: To the band man	e best of my knowledge, deat easis of examination and/or in oner stated.	th occurred at the tim evestigation, in my op	e, date and place, an binion, death occurred	d due to the caus I at the time, date	e(s) and manner as s and place, and due t	tated. o the cause(s)
	To the within To the comp	M	29b. Signature and title by contifier		29c. License			Date signed (Month.	
_	10,		30. Name and address of person who completed cause	is Northw	Print) Jest Hoa	yetal 1	Bultime	raich z	71133
••	Sta Registr		Cara III	Registrar's Signature	& door				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** March 23, 8:28 A M 2005 Olga Morrow /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Mayfield House Catonsville Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Min. Hours 1 M 2 F 78 214-20-6013 Director New Jersev Usual Residence of Decedent e filed within 72 hours after death with the Maryland at Hygiene.
other then "nature!", or items 23e or 28a-f ehow 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or items 23e or 28a-f ehow the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Maryland Anne Arundel Linthicum Heights 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 411 West Maple Road 21090 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No ģ Specify. White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker permit. Pages 1 and 2 should be file Department of Health and Mental Hy importent: if Item 27 Ie marked other any Injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Frank A. Roche Mary A. Hendry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia A. Smith/Niece 411 West Maple Road, Linthicum Heights, MD 21090 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Metro Crematory, Inc. 3/24/05 Baltimore, MD <sup>22</sup> Name and Address of Facility
Cremation Society of MD, Inc.
299 Frederick Road Baltimore, 21. Signature of Funeral Service Licensee Thomas Gregor 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or gach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** neumonia /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner rtérios de votio cardiovas cular deseise attending physicien and for use as the burial-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) the a signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 3 Probably 4 Unknown Completed 24b. Were autopsy lindings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has autopsy performed? Yes 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Assisted Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗋 Yes 2 No 1 Inpatient 2 ER/Outpatient Certification: To 3□ DOA Living 27. Manner of Beath 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funerel Director: filled in by the 6 Could not be determined 3 🗌 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Image: Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

Registrar

M

State

29b. Signature and title

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Olwine MD

036246

606 Hammonds La Ste LZ Brooklyn Park MD

29d. Date signed (Month, Day, Year)

05-02029 RKD

	State of State of T- For Unpend Item 23a,27,28	Maryland / Department of L 28a-f per me G843 5-16 Certificate of	Health and Mental Hygi Death Re	ene 005   0029
	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	3. Time of Death
Physician /Medical		HAE MAYO	MARCH	<sup>Day</sup> 20, 2005 3:18P. M
Examiner	A Partie Alexander Martin at the second		r Location of Death	4c. County of Death
	JOHNS HOPKINS BAYVIEW MED		IMORE	NIA
Funeral Director	5. Social Security Number 6. Sex	7. Age (In yrs. last birthday) If Under 1 Year Yrs. Months Days	Hours Min. 8. Date of Birth Month, Day,	7 . 200 1
0	Usual Residence of Decedent	1 115. 5	UC1. 1,	2003 MARYLAND
yland	10a. State 10b. County	10c. City, Town or Location	2	10d. Inside City Limits
the Marylar 28a-f show cylified at	MARYLAND NIA	BA	LTIMORE CIT	1 A Yes 2 No
or 24	10e. Street and Number	10f. Zip Code		g. Citizen of What Country?
s 23a	3042 EDMONDS	IN AVENUE	21223	USA
6 alter death with the Maryla or itams 23a or 28a-1 shou onher count by contined at	11. Marital Status 12. Was Dece Armed For 1 Never Married 2 Married 1 ☐ Yes	dent Ever in U.S.  ces?  If Yes, specify Cub	tispanic Origin? (Specify Yes or No- an, Mexican, Puerto Rican, etc.)	<ol> <li>Race - American Indian, Black, White, etc.</li> </ol>
urs aff		1 Yes 2 No	Specify:	Specify: BIACK
d 21215-0036  filed within 72 hours after death with the Maryland Hygiene.  that then "natural", or items 23a or 28e-1 show int, the Medical Examinational by mortified at a Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occup	pation 1	6b. Kind of Business/Industry
within 7	Elementary/Secondary (0-12) College (1	(Give kind of work done life. DO NOT use retire	during most of working d)	/
nd 212 a filed with Il Hygiene. other the vent, Ibe N	17 Fatherte Name (First Middle (1991)	N/	A	N/A
Maryland 21215-0036 d.2 should be filed within 72 hours all th and Mental Hygiene. T is marked other than "natural", or traumatic event, the Medical Exami	17. Father's Name (First, Middle, Last)	1 110111	18. Mother's Name (First, Middle, M.	~
Le should be name Mental its marked or raumatic ave	PARIS FABIA  19a, Informant's Name/Relationship (Type, Print)		and Number or Rural Route Number,	CHELLE PRETTYMAN
iore, Maryland 21215 ges 1 and 2 should be filed within 7: t of Health and Mental Hygiene. If item 27 is marked other than "n or other traumatic event, Ire Meni To Be Comple!				
ore, M	20a. Method of Disposition	20b. Place of Disposition (Name of	Date 2	10. HD. 21223  Oc. Location - City or Town, State
Baltimore, permit. Pages 1 ar Department of Hea Important: If item any injury or othe once.	1 💆 Burial 2 □ Cremation 3 □ Removal from 5  '4 □ Donation 5 □ Other (Specify)	State cometery, crematory or other plants	1 2 2 2	JOODLAWN, MD
altii	21. Signature of Funeral Service Licensee	22. Name and A dre	ss of Facility	D FUNERAL HOME
Bal permi Depa Impo any is	I which N. U	Ilhams 2140 N	FOLTON AVE.	R. FUNERAL HOME BALTO, MO 21217
	23a. Part1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on ea	used the death. Do not enter the mode of dyin		
Physician	Immediate Cause (Final	ia due to aspiration o	of food material i	Onset and Death
/Medical Examiner	resulting in death)	or as a consequence of):	7	area dari way
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executed in and ial-transit	r any, leading to immediate cause. Enter Underlying Cause (Disease or injury	or as a consequence or):		
al-trae	that initiated events c. resulting in death) Last Due to (	or as a consequence of):		
P.O. Box 6876( hat the death certificate be do by the attending physicis detached for use as the bun Physician/Medical				
of Vital Records, P.O. Box 68 Physician: The law requires that the death certific this certificate has been signed by the attending p rat director, page 2 should be detached for use as: TO Be Completed by Physician/Mec.	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, out	come of pregnancy rth 2 □ Fetal death 3 □Ectopic pregnancy	,	23d. Date of delivery
O. B ne dear the att thed fo	in the past 12 months?  1 ☐ Yes 2 ☑ No  9 ☐ Unkno	ant at time of death 5 Other (specify)	· · · · · · · · · · · · · · · · · · ·	Month Day Year
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Division of Vital Records, or Attanding Physician: The law requires tafter death.  Director: After this certificate has been signed in by the funeral director, page 2 should be ertification: To Be Completed by	25. Was case referred to medical examiner?  X Yes 2 No  Hospital: 1 Ir	nationt 2 VER/Outnationt 2 II DOA Oth	26. Place of Death (Check only one,	
Of \ physical Physical Physical direction To	27. Manner of Death 28a. Date of	f Injury 28b. Time of 28c. Injur	4   Notsing Home 5   Residen	
ion ath. :: Afte	1 □ Natural 5 □ Pending 3 − 20° 20° 21° Accident investigation found	103 Z.33 M 1	Yes 2X No subject a	spirated food material
VIS Atta	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place buildin	of Injury - At home, farm, street, factory, office g, etc. (Specify)	28f. Location (Stre	get and Number or Bural Route Number, State) 7911 Eastern Avenue
Division call or Attending P is after death.  al Director: Attert ded in by the funera	parki	ing lot of restaurant	Baltimore	Maryland
Division of Vital Recomplished on Attending Physician: The law within 24 bours after death. To the Funeral Director: After this certificate has accompletely filled in by the funeral director, page 2. Medical Certification: To Be Comp		best of my knowledge, death occurred at the tir sis of examination and/or investigation, in my o	ne, date and place, and due to the cau	use(s) and manner as stated.
thin 24 thin 24 omplete		er stated.		
T W CY	29b. Signature and title of certifier	29c. Licens OCM	2	d. Date signed (Month, Day, Year)
A dus	Marken M. Le 15	and	MA	ARCH 21,2005
1 per	30. Name and address of person who completed suse	o of death (Item 23a) (Type, Print) 111 Penn S	Street Baltimore.	Maryland 21201
s State			,	-
Registrar	MAR 2 4 2005	gistrar's Signature		

			For State Registrar	State	of Maryla	and / Dep	artment <i>rtificate</i>			nd Me		giene () leg. No.	05	100	)30
	Physic /Medi		1. Decedent's Name (First, Middle Frances	o, Last)	M	acer					2. Date of Dea Month March 23	Dav	Year	3. Time	of Death
	Exami	ner	4a. Facility Name (If not institution Haven Nursing Hom		ımber)			own, or L Lt <b>imo</b> n	ocation of C	Death		4c. Cour	nty of Death	1	
	Funeral Director		5. Social Security Number 212–18–3736	6. Sex 1 ☐ M 2 ☐ XTF	7. Age (In your 101	rs. last birthday) Yrs.	If Under 1 Months	Year Days	If Under 24 Hours	Hrs. 8 Min.	B. Date of Birth (Month, Day March 29	, Year) 1903	Coun	lace (State try) Carol:	e or Foreign ina
	faryland ehow	٥	Usual Residence of Decedent  10a. State 10b. County  MD N	 А	10c.	City, Town or Lo	cation						1		City Limits
	or 28e-	Director	10e. Street and Number			Idi	10f. Zip C	ode			1	0g. Citizen c	of What Coun		es 2 No
	s 23a	rai	3130 Parkington Av	-					21215			USA			
5-0036	be filed within 72 hours after death with the Maryland tal Hygiene. Identify then "naturel", or Items 23a or 28e-f ehow event, the Medical Examera must be notified at	Completed by Funeral	11. Marital Status  1 Never Married 2 Marri 3 Widowed 4 Divorced	Amed F	2 XNo		Was Decede f Yes, specif 1 ☐ Yes 2	_	anic Origin' Mexican, P Specify:	? (Speci verto Ri	fy Yes or No- can, etc.)		ace - Americ lack, White, e		
21215-0	ithin 72 ho ne. han "natur b Wedical	npieted	15. Decedent (Specify only highes Elementary/Secondary (0-12)	s Education t grade completed) College (	1-4or 5+)	16a. Deced (Give life. I	lent's Usual kind of work DO NOT use	Occupation done dur retired)	on ring most of	working		16b. Kind of			
2	filed withi Hygiene. other than		17. Father's Name (First, Middle, L	act)			Homema		0.14				omestic		
Maryland	s 1 and 2 should be if Health and Mental i item 27 Is marked o other treumatic eve	To Be	Barney Douglas  19a. Informant's Name/Relationsh	_		105 11-15-			M	1aggie	First, Middle, Me Rosebo	rough			
	and 2 sealth an 27 ls		Albert P. Wylie	ip ( <i>Type</i> , Print)							Route Number,		n, State, Zip	Code)	
altimore,	Pages 1 a		20a. Method of Disposition 1 🖾 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp	3 □Removal from	State	Place of Disposementary, crem	sition (Name natory or othe	of		Date -26-05	θ 2	20c. Location		wn, State	
Balti	permit. Pages Department of Importent: If ii any injury or once.		21. Signature of Funeral Service L		)	22	. Name and		of Facility	C	38 N. Gi			MD 21	 1217
	Physician /Medical		23a. Part1. Enter the disease, or of shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	a	iacri iine.	rac a						st,		Approxima Interval Be Onset and	tween Death
ļ	ficate be executed by physician and sthe burial-transit and	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	or as a conse	equence of);	we 1	1000		411·e	as-e		1	erl-3	
O. BOX 6	The law requires that the death certificate be executed attents been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, out 1 Live b 4 Pregn 9 Unkno	irth 2 ☐ Fet ant at time of	al death 3 1	Ectopic pregr Other (specia						ate of delivery		Year
cords, r	w requires that been signed b should be deta	by	Part II. Other significant condition	s contributing to de	eath but not re				n Part I.		23e. Did toba	acco use con	tribute to the		
מו שבנס	rsicien: The law rec s certificate has bee lirector, page 2 shou	Completed								-	24a. Was an autopsy perform	24b.	Were autops prior to comp death?	sy findings	available
N I G	ysicie s certi directo	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	npatient 2	TER/Outpotions	00.004	0.1			heck only one				
5	I of the Nospile or Attending Physicien: The within 24 hours after death.  To the Funerel Director: After this certificate his completely filled in by the funeral director, page.	ation; T	27. Manner of Death 1 Natural 5 Pending 2 Accident investiga	28a. Date of (Monti		28b. Time of Injury		Injury at Work?	2 No		5 Resident				
	To the Hospitel or Attendi, within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Certification;	3 Suicide 6 Could no determin	ad 288. Place	of Injury - At h	ome, farm, stree fy)	et, factory, of	fice		28f.	Location (Stre City or Town,	et and Numb State)	per or Rural P	Route Num	ber,
	ne Hospi in 24 hour he Funer pletely fill	edical	29a. Certifier (Check only one)  1 Certifying 2 Medical Ex	Physicien: To the aminer: On the ba and mann	313 OI OVEILLING	owledge, death a ation and/or inve	occurred at the stigation, in a	ne time, c	date and pla on, death oc	ce, and	due to the cau It the time, date	se(s) and ma e and place,	anner as state and due to th	ed. ne cause(s	)
ı	To I com	Σ	29b. Signature and title of certifier				29c. Lid	D3	mber 64억4	4	290	I. Date signe	d (Month, Da	ıy, Year)	
	3		30. Name and address of person wh	o completed cause				P	alhma	ore	mp &	1228			
j	Stat Registra	te ar	31. Date filed (Man ARY, Year)	2005	gistrar's Signa	Aure do	W.								

hysici		1- For Amend Item 1 per me GE	Ce	rtificate of L				10031
	an	1. Decedent's Name (First, Middle, Last)				2. Date of Deat Month MARCH	19 <sup>Day</sup> 2005 <sup>Year</sup>	3. Time of Death
/Medic		Charles G. Murel  4a. Facility Name (If not institution, give street and number)		4b. City, Town, or		'IAKCI		2:26a
Examin	ıer	1800 BLOCK EDMONDSON AVENUE	Married In add to instruction and	BALTIMORI	E CITY		4c. County of Death	
ineral rector		5. Social Security Number  219-78-3838  Usual Residence of Decedent  6. Sex  1 M 2 □ F  7. Age	(In yrs. last birthday)  34 Yrs.	Months Days	Hours Min	8. Date of Birth ( <i>Month, Day,</i> 16–15–1970	Yeari Co	nplace (State or Foreig untry) land
show		10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limi
e-d st	tor	MID NA		Baltimore				1 Yes 2 □ N
28 or 28	irec	10e. Street and Number		10f. Zip Code		10	g. Citizen of What Cor	untry?
23e C	alD	2803 E. Chase Street			21213		USA	
"neturel", or Items 23e or 28e-f shov official Exeminer must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent E Armed Forces?  1 Yes, Give Year or Dates:	0	Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 🛣 No	spanic Origin? (Spec n, Mexican, Puerto R Specify:	ify Yes or No- ican, etc.)	14. Race - Amer Black, White Specify: Blace	e, etc.
eture	ted	15. Decedent's Education	16a. Dece	dent's Usual Occupa	tion	1	6b. Kind of Business/l	
	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5-	life.	kind of work done di DO NOT use retired)	uring most of working	9	ob. Time of Education	industry
	No.	12	7	Cook			Restaurant	
	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, M	laiden Sumame)	
	To	Charles Gilbert Sr.			Diane Sm	ith		
2 2		19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street a	nd Number or Rural	Route Number,	City or Town, State, Zi	ip Code)
ther tr		Andrea Murel/ Wife		Chase St.				
If item or othe		20a. Method of Disposition  1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Dispo cemetery, crer	osition (Name of matory or other place	) Da	te 2	Oc. Location - City or T	own, Slate
jury i		`4 □Donation 5 □ Other (Specify)	Mt. Zion Ce	metery	03-24-0	5 L	ansdowne, MD	
Importent: If its any injury or o QDCs.		21. Signature of Funeral Service Licensee		2. Name and Address lylie Funeral	*	. Gilmor	St. Balto, MI	21217
physician and the prival-transit the purial-transit	dical Examiner	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	consequence of):					
독등	0							
or use as	hysician/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  23c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deliv Month	ery Day Year
igned by the attending be detached for use as	٩	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No	Fetal death 3 me of death 5	Other (specify)	n in Part I.	23e. Did toba	Month	Day Year the cause of death?
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rer briecous, when this certificate has been signed by the attending fled in by the funeral director, page 2 should be detached for use as	ledical Certification: To Be Completed by	23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions contributing to death but  25. Was case referred to medical examiner? 1   X'es 2   No	Fetal death 3 me of death 5 me of death 5 me of death 5 me of resulting in the ur  2 ER/Outpatien  28b. Time of Injury  28b. Time of Injury  4. At home, farm, stre (Specify)  my knowledge, death xamination and/or inv	other (specify)  Inderlying cause giver  at 3 DOA Other  28c. Injury a Work?  M 1 Ye eet, factory, office	26. Place of Death (in the second sec	24a. Was an autopsy perform Yes 2[ Check only one of 5 Residen d. Describe how City or Town, at the time, date at the time, date 290]	Month  24b. Were autorior to condend?  No 3 Prol  24b. Were autorior to condend?  No 10 Prol  24b. Were autorior to condend?  10 Prol  24b. Were autorior to condend?  10 Prol  24b. Were autorior to condend?  10 Prol  24b. Were autorior to condend.  25c. Sec. Sec. Sec. Sec. Sec. Sec. Sec. Se	baby Year  the cause of death?  bably 4 Dunknown  ppsy findings available  pmpletion of cause of  2 No  (y) SCENE  al Route Number,  tated.  o the cause(s)  Day, Year)
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			For State Registrar	State of	Maryland /		artment of F				giene Reg. No:	105	10033
	Dharata		1. Decedent's Name (First, Middle,	Last)				•		2. Date of De Month		Vone	3. Time of Death
	Physici /Medic		CONCETTA			N	100R€			MARCH		2005	4:00 PM
).	Examir		4a. Facility Name (If not institution,	-	er)		4b. City, Town, or		of Death		4c. Coi	inty of Death	
6			HARBOR HUSPI		A // / /	- (	BALT IM		O4 Hea				
	Funeral Director		5. Social Security Number  214.66.3645  Usual Residence of Decedent	3. Sex 7.	Age (In yrs. last t	Yrs.	Months Days	If Under Hours	Min.	8. Date of Bird (Month, Da MARCH	y, Year)	Cou	place (State or Foreign ntry) TALY
	land ow		10a. State 10b. County		10c. City, To	wn or Lo	cation						Od. Inside City Limits
	within 72 hours after death with the Maryland ane. than "natural", or itams 23c or 28a-f show ha Wedical Evantiar must be rediffed at	to	MD ANNE A	RIIMDFI	GLEN	RIIDI	NT F						1 □Yes 2□No
	r 28a	Director	10e. Street and Number	KUNDEL	OLLIV	Build	10f. Zip Code				10g. Citizen	of What Cou	
	th wit		304 CHALMERS	AVE.			21061				и	SA	
	ams	Funeral	11. Marital Status	12. Was Decede Armed Force	ent Ever in U.S.	13. \	Was Decedent of H f Yes, specify Cuba	ispanic Ori	igin? (Sp	ecify Yes or No Rican, etc.)		Race - Americ Black, White,	
36	ours afte rai', or if Evantin	<b>by</b> Fu	1 Never Married 2 Marrie	If Yes, Give			1□Yes 2□No	Specify:		, , , , ,		ecify:	GIG.
Ö	hour tural		3€Widowed 4 □ Divorced 15. Decedent's	Year or Date				-Ai				WH	ITE
21215-0036	d within 72 hours giene. ar than "natural", the Medical Eval.	Completed	(Specify only highest	grade completed)		(Give	dent's Usual Occup kind of work done of DO NOT use retired	durina mos	t of work	ing	16b. Kind o	of Business/In	dustry
212	iene.	mo	Elementary/Secondary (0-12)	College (1-4		CUSTO	ODIAN	7			44	co. sc	HUUI G
	調子会員	0	17. Father's Name (First, Middle, L.	ast)			2.4.	18. Mothe	er's Name	e (First, Middle,			1100123
Maryland		To B	unk	ROSSI				unk					
Jan	and s m		19a. Informant's Name/Relationshi				ng Address (Street						Code)
	itam 27 i		CONCETTA WELDON	DAUGHT			HOMEWOOD	KV. L		-			
Baltimore,	Page nent c ant: if ary or		20a. Method of Disposition  1	3 □Removal from Sta			sition (Name of matory or other place LLS CEMET	ERY		0.2005		MORE,	
Balt	perr it. Dep rtr Importa any inji		21. Sign to of Funeral Service L	FINK I	101148	F 1	INK FUNER 26 CRAIN	AL HO	ME,	P.A.	ITE 18	0 0104	1
			23a. Part . Enter the disease, or o		sed the death. De	o not ent	er the mode of dyin	g, such as	cardiac	or respiratory as	rest,	ZIVO	Approximate
	Pnysician		Immediate Cause (Final disease or condition	<i>y</i> .	MONIA								Interval Between Onset and Death
	/Medical		resulting in death)		as a consequenc	e of):							one week
	Examiner		Sequentially list conditions,	b. ACUTE	E RESPIR	LA70	124 DIST	2555	SYN	DROME		1	NE WELK
	sit ad	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to (or	вя а сопязіднено	e offr							
	and and -trans	Kam	that initiated events resulting in death) Last		ESTIVE as a consequence		LT FAIL	ure				Τ	HREE DAYS
8760,	be ey ician buria			Due to (or	as a consequenc	e oi).							
387	The law requires that the death cartificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical		d									
9 xc	death certifica attending phate of for use as t	Physician/Me	IF FEMALE:	23c. If yes, outco	me of pregnancy						224	Date of delive	
Вох	leath atter	ciar	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birt!	n 2 ☐ Fetal dea t at time of death		Ectopic pregnancy Other (specify)				230.	Date of delive Month	Day Year
0	that the ded by the detached	hysi	1 Yes 2 No 9 Unknown	9□ Unknow						F= 1330			
<u>ر</u>	res that igned b		Part II. Other significant condition	s contributing to deal	h but not resulting	in the ur	nderlying cause give	en in Part I.		23e. Did to	obacco use o	ontribute to tl	ne cause of death?
rd	v require been sig should b	edt	HYPERTENSION	ANEMI	4					VES	res 2□N	3 ☐ Prob	ably 4 Unknown
Vital Records,	iaw requasi ss been 2 shoul	Completed by								24a. Was		b. Were auto	psy findings available
Ä	The lav ate has page 2:	mo:								autop perfo	med2	prior to co death? 1  Yes	mpletion of cause of
ita	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?					26. Place	of Death	Check on o			20110
of V	S S	္န	1 ☐ Yes ₺⊉No	Hospital:		Outpatien	t 3□ DOA Oth	er: 4□Nu	rsing Ho	me 5 🗆 Resid	lence 6 🗆	Other (Specif	y)
n o		on:	27. Manner of Death  1 □ Natural 5 □ Pending	28a. Date of (Month,	njury 28b <i>Day Year)</i>	. Time of Injury	28c. Injun Work	v at k?		28d. Describe h			
Sic		icat	2 Accident investiga 3 Suicide 6 Could no	t he				Yes 2 □ I					
Division	or Attsno after death Director: in by the	Certification:	4 ☐ Homicide determin	and I 286. Place of	Injury - At home, etc. (Specify)	farm, stre	eet, factory, office			28f. Location (S City or Tow	Street and Nu m, State)	imber or Rura	l Route Number,
_	a Hospital or 24 hours afte a Funaral Dir etely filled in		29a. Certifier W Certifying	Physician: To the h	et of my knowled	na death	a accurred at the fire	- date -	d place	and due to the	anuac/s) :		
	a Hos a Fun	edical	(Check only one)	Physician: To the be kaminer: On the basi and manner	s of examination a	ge, death and/or inv	estigation, in my or	ie, date an pinion, dea	d place, i th occurr	and due to the ded at the time, o	ause(s) and date and plac	manner as s ce, and due to	ated. the cause(s)
	To tha Hospital or At within 24 hours after of To tha Funaral Direct completely filled in by	Me	29b. Signature and title of certifier				29c. License	number			29d. Date sig	ned (Month,	Day, Year)
			De alloulenj	*			RESC	100			MARCE	1 27-	2005
	15		30. Name and address of person w		of death (Item 23a	) (Type, i		LK	UICE		, , , , (		
	1		3001 SOUT	4 HANG	VER S	1260	=1 BF	LTIM	WRE	MARI	1LANT	212	25
	Sta		31. Date filed (Month, Day, Year)	2005 32. Feg	istrar's Signature	R.	act s				_		
	Registr	ar	WAR 24	TOOL CON	was so.	M							

		1- State of Maryland / Registrer		rtment of He tificate of D				iene	005	10034
9		1. Decedent's Name (First, Middle, Last)					2. Date of Deat Month	h Day	Year	3. Time of Death
Physicia /Medic		George William Neuge	ent,	Jr.			March 2	24, 2	.005	6:25 A M
Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or					ounty of Deat	
		Manor Care Woodbridge Valley  5. Social Security Number 6. Sex 7. Age (In yrs. last a	birthday)	If Under 1 Year	If Under	V111€ 24 Hrs.			Baltin	
Funeral Director		215-05-8553 1 <sup>1</sup> XM <sup>2</sup> □ F 93	Yrs.	Months Days	Hours	Min.	8. Date of Birth (Month, Day JUL 1	, Year 19	11 M	hplace (State or Foreign buntry) aryland
2		Usual Residence of Decedent  10a. State 10b. County 10c. City, To	um ar la	ention						I dod Jasida Cir. I init
shov	5	Maryland Baltimore 10c. City, To	WIT OF LOC		onsv:	:110				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
28e-f	Director	10e. Street and Number		10f. Zip Code	OHSV.	ттте	1	0g. Citize	n of What Co	
3e or	D	120 Oak Drive		21228					USA	
ams 2	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of His Yes, specify Cubar	panic Ori	gin? (Spe	cify Yes or No-		. Race - Ame Black, White	
or the		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 💆 No If Yes, Give	í	☐ Yes 2X No	Specify:		nour, etc.,	s	pecify:	
tural'	ed by	3 X Widowed 4 □ Divorced Year or Dates:	Sa Deced	ent's Usual Occupa	tion				of Business/	White
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al Hy d otha	Be	17. Father's Name (First, Middle, Last)			18. Mothe	er's Name	(First, Middle, I	Maiden St	umame)	
1 Men narke	ဥ	George William Neugent, Sr.  19a. Informant's Name/Relationship (Type, Print)	01 44 15	g Address (Street a			a Woods	0: 7		
than traur		Carole Neugent Coss/Daughter		' Cedar Pa				,		
f Heal itam itam other	1,8	20a. Method of Disposition 20b. Place	of Dispos	sition (Name of natory or other place	1				ition - City or	
nent o		1 Li Buriai 2 La Cremation 3 Li Hemovai from State	-	ematory,	1	3/26	/05	Ba1	timore	e, MD
penint. ragss trains and the minint rations are read in the way has been must be way as been trained to the manual Hygiene. If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Moderal Exemitret mat be notified at once.		21. Signature of Funeral Service Licensee	22	Name and Address MacNabb F	of Facilit	y a1 Ho	me P.A			
20129		Edward A. Gregorchik		301 Frede	rick	Road	Catons	V111	e, MD	
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xaminer		Due to (or as a consequence	e of):							
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attending p	M/M	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal dea	ub 2□	Ectopic pregnancy				230	d. Date of del	ivery
he atte	by Physiclan/M	1 Yes 2 No		Other (specify)					Month	Day Year
d by t	Phy	9 Unknown  Part II. Other significant conditions contributing to death but not resulting	n in the un	Iderlying cause give	n in Part I		23e Did tob	acco use	contribute to	the cause of death?
signe		Ltu aestensum	9 111 (110 011	derlying oddse give	THIT CITY	•		s 2 🗆		
peen	Completed						24a. Was a	n i	24b. Were au	Itopsy findings available
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his ce	To		Outpatient	t 3□ DOA Othe	4 <b>Y</b> Nu	rsing Hon	ne 5 🗆 Reside	nce 6[	Other (Spec	cify)
After t	lon:	1 Natural 5 Pending (Month, Day Year)	. Time of Injury	28c. Injury Work' M 1 □ Y	at ? es 2 □		8d. Describe ho	w injury o	occurred	
death ctor: y the	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home.	farm, stre		es 2 🗌		8f. Location (St.	reet and I	Number or Ru	ıral Route Number,
after I Dira	Certification:	4 Homicide building, etc. (Specify)	,	,			City or Town			
The first properties of the fundamental of the form requires that the definition of the fundamental of the f	edical (	29a. Certifier 1 Certifying Physician: To the best of my knowled 2 Medical Examiner: On the basis of examination	lge, death	occurred at the time	e, date an	d place, a	nd due to the ca	ause(s) ar	nd manner as	stated.
tha F	Medi	one) and manner stated.								
T W T CO		29b. Signature and title of certifier hp		29c. License	156	4	2	Ju. Dale S	signed (Montl	
		30. Name and address A person who completed cause of death (item 23a	a) (Type f	Print)	_		Rene	Marc	h 24,	2005
10		Klen atten	an	18	38	6	Rene	1~	ee	the znot
Sta Registr		31. Date filed (Month, Day, Year)  MAR 2 4 2005	Asset .							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 9:02PM **Physician** 2005 Alex Noal Charlie /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner Himore Hospital Mai If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Nonths Days Hours Min. 01 15 2 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** XXM 2DF 79 Yrs. ۷Á Director 219-16-6648 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland ral', or Itams 23a or 28a-f ahov Experient reast be notified at XXYes 2 □ No Director Baltimore NA MD 10g. Citizen of What Country? 10f Zip Code 10e. Street and Number with Road Apt C-2 3601 Labyrinth 21215 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Y☐ Yes 2☐ If Yes, Give Year or Dates: Never Married 2 ☐ Married 2 No 1 ☐ Yes 2 X No Specify: Specify: β 3 Widowed 4 Divorced Black natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) th and Mental Hygiene.

7 is marked other than "natur traumatic event, it is M. Alc. 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Bethlehem Steel Battery Operator 10th grade na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Rosie Brown Charles Noel Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) itam 27 517 Oakland Ave, Baltimore, Md Eugene Noel-Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c Location - City or Town State 20a. Method of Disposition Department of h Important: If its any injury or ot once. Burial 2 □ Cremation 3 □ Removal from State
 Donation 5 □ Other (Specify) Garrison Forest Vet. 3/28/05 Owings Mills, Md 21. Signature Funeral Service Licensee 22. Name and Address of Facility
March F/H West 28a. Pyrt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21215 4300 Wabash Ave, Baltimore, Md Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MOSEP81 Weeks disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** relmon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, à MD 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 212 No 2 No 1□ Yes 1 Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No 2 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Diractor: 6 ☐ Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certific

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To the Hospital or Al within 24 hours after or the Funeral Dirac completely filled in by Medical Certiff

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Registrar

eath (Item 23a) (Type, Print)

32. Register's Signature

OSOITA

30. Name and address of person who completed cause of death (Item Both Y. Warm, DO Sha

State of Maryland / Department of Health and Mental Hygiene ( Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year Dorothy Maxine Neiberger March 16, 2005 2:55 P /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Greater Baltimore Medical Center Towson Baltimore 8. Date of Birth (Month, Day, Year) Jan 26, 1926 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Colorado **Funeral** Days 1 □ M 2 🗑 F Director 523-20-2535 Usual Residence of Decedent death with the Maryland 10a, State 10b. County 10c. City, Town or Location item 27 is marked other than "netural", or items 23a or 28e-f show other treumatic event, it's Modical Examinar must be notified at 10d. Inside City Limits Funeral Director 1 ☐ Yes 2 ☑ No Maryland Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3500 North Wind Road 21234 USA permit. Pages 1 and 2 should be filed within 72 hours after dea.
Department of Heelth and Mental Hygiene.
Importent: If frem 27 is marked other than "netural" or in-12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No ff Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Be Completed by 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sherrill Osborne Jean Roberta Arthurs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Jeannie Stewart/Daughter 3500 North Wind Road, Parkville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State ' 4 Donatton 5 ☐ Other (Specify) Olinger's Highland Cemetery Thornton, Colorado Funeral Service bigerise 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley Inc. Bryan W. Clary 10 W. Padonia Road, Timonium, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) **Physician** seby dration days /Medical Due to (or as a consequence of): **Examiner** Due to (or as a consequence of): Iraut Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Renal burial-transit or Attending Physicien: The law requires that the death certificate be executed Acute the attending physicien and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical Arteni years oronaru Diseuse as the 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 □Ectopic pregnancy Dav Year 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown signed by Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vascular disease 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown been Old Cerebral Vascular 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? this certificate Hypertension 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3 DOA in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Natural 5 Pending death. 1 TYes 2 TNo investigation after death Director: 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospitel within 24 hours a To the Funeral L Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 29b. Signature and title of dertifier 29c. License number 29d. Date signed (Month, Day, Year) Kannok D047223 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Karen M. Piper MD Charles Strect Bultimore mD 67Di 31. Date filed (Month, Day, Year) 32. Resistrar's Signature State 2005 Registrar

DHMH 17 Rev 1/2001

leiberger, Broth

		1	State of Maryland / Department of Health and M  1- State  Certificate of Death		2000 10001
			1. Decedent's Name (First, Middle, Last)	Reg. N	3. Time of Death
	Physicia		Louis Naumann	Month Di	ay Year 9:45PM
	/Medic		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death		c. County of Death
	Examin	er i	North Anywhol Hospital Glew Bunn	110 1	Ining Animalal
	Funeral		5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under Year 1 Under 24 Hrs.	8. Date of Birth (Month, Day, Year Jan. 28,	9. Birthplace (State of Foreign
	Director		219-03-5220 X M 2 F Yrs. Months Days Hours Min.	Jan. 28, 1	1919 Maryland
	pu 🛊	<u>}</u>	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
	aho aho		MD Anne Arundel Glen Burnie		1 ☐ Yes 2 ☐ No
	28a-	ect -	10e. Street and Number 10f. Zip Code	10g. C	Citizen of What Country?
	3e or		10 Glen Oak Lane N.W. 21061	USA	<i>Y</i>
	death	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp. Armed Forces? If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian, Black, White, etc.
õ	or Its	Fu	1 □ Never Married 2 □ Married 1 □ Yes 2 □ No 1941 - 1 □ Yes 2 □ No Specify:		Specify: White
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'n	"nat	Completed	15. Decedent's Education (Specify only highest grade completed)  (Give kind of work done during most of work life. DO NOT use retired)	king 165.	Killa of Basiness/filoasily
7	withii iene. then	mo	Elementary/Secondary (0-12) College (1-4or 5+)  9 Carpenter		Carpentry
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yland	Menta Menta rked ric ev	To B	John Naumann Katherin	ne Allen	
Mary	should have and have some		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rule)	ral Route Number, City	or Town, State, Zip Code)
Ξ	is 1 and 2 should be filled within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other then "natural", or Itams 23e or 28a-f ahow other traumatic evant, the Medical Examinational be notified at		Robert Naumann/Son 924 Sunnybrook Drive (		Location - City or Town, State
ore	Pages 1 nent of Ha ant: If iter		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	cn 24,	
Ē	Pag tment tent: jury		4 □Donation 5 □Other (Specify) Glen Haven Memorial 2005	G1e	en Burnie, MD
Baitimore	permit. Pages 1 an Department of Heal Importent: If item 2 any injury or other once.		Singleton Funeral I	Home, P.A.	1 Second Ave. S.W.
	402 4 4		23a Part Enterthe disease or complications that caused the death. Do not enter the mode of dying, such as cardiac		Approximate
			shock, or heart faylure. List only one cause on each line.		Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a		
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×	eath certific attending p	Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant		23d. Date of delivery
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Division of Vital Records,	or Attanding Physician: after death. Diractor: After this certifics in by the funeral director. I	flcat	Accident investigation  A Suicide 6 Could not be determined  28e. Place of Injury - At home, farm, street, factory, office		and Number or Rural Route Number,
<u>≤</u>	i Sitt	Certification:	4 Homicide building, etc. (Specify)	City or Town, Sta	ate)
	To the Hospitel or At within 24 hours after or To the Funaral Diract completely filled in by			, and due to the cause	(s) and manner as stated.
	he Ho n 24 he Fu pletel	edical	one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur		
	To t To t	Σ	29b. Signature and title of certifier 29c. License number		Date signed (Month, Day, Year)
1	/		) Gerlin 0005570.	3 3	5/21/05
	5		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	6.1	
	* Sta	to	Tsion Berhane 301 Hospital Drive, Glen Burnie, MD 210  31. Date filed (Month, Day, Year)  32. Registrar's Signature	01	
2	Regist		MAR 2 4 2005		

DHMH 17 Rev 1/2001

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	/Medic Examir		4a. Facility Name (If not institution, gi		9r)	11.05	4b. City,	Town, or	Location of	of Death	1 -11/1	4c. County of		) ) F W
			5, Social Security Number 6.	Sex 7.	IHC)	4125	If Under	1 1 1 2 2 1	If Under	10/2C	Data of Birth	n/a		
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	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	ocation						10d. Inside C	City Limits
	Mary illed	tor	MD n/a		Ва	ltimor	e Cit	v					1XX Yes	s 2 No
	or 28	Director	10e. Street and Number				10f. Zip				10	g. Citizen of W	hat Country?	
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36	be filed within 72 hours after death with the Maryland Ital Hygiene. od other than "natural", or Itema 23a or 28e-f show event, I're Medical Exa ofter med be rectified at	/ Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decede Armed Force 1 ☐ Yes 21 If Yes, Give	s?		Was Deced If Yes, spec 1 ☐ Yes 2	rfy Cuba	n, Mexican	gin? (Specify n, Puerto Ric white	an, etc.)	Black	- American Indian, , White, etc.	
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Maryland 21215-0036	S E S	Be	17. Father's Name (First, Middle, Las	t)								aiden Sumame	)	
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re,	of Health of Health litem 27		20a. Method of Disposition		20b. P	Place of Dispo	sition /Nam	e of		Daltim		aryland Oc. Location - C	21229 City or Town, State	-
<u>im</u>	Pages nent of I ant: If ite ury or o		1 ☐ Burial 2 ☐ Cremation 3 (		te Bal	emetery, crei timore oudon	Crem Park	ator	<sup>ў</sup> 3-	-17-20	05 Ba	altimor	e City	
Baltimore,	permit. Pages Department of important: If i any injury or once.		21. Signature of Funeral Service Lice	ensee AMA	21								al Home and 21229	
			23a. Parri. Enter the disease, or cor shock, or heart failure. List only	nplications that cause on each	sed the deat								Approxima Interval Be	te
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	/Medical Examiner		resulting in death)	Due to (or	as a conseq	uence of):		101			-1112/		11	100
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Ó,	e exec ian an urial-tr	Exa	resulting in death) Last	Due to (or	as a conseq	uence of):								
8760,	death certificate be executed e attending physician and of for use as the burial-transit	dical		d		_								
Box 6	eath certific attending p	lan/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor	ne of pregna	ancy						22d Data	of delivery	
	the death y the atter ached for u	Physician	in the past 12 months?  1 Yes 2 No 9 Unknown	1⊡Live birth 4⊡Pregnani 9⊡Unknowr	at time of d		Ectopic pre Other (spe					Mon	,	Year
P.0	that ed b deta	/ Ph	Part II. Other significant conditions	contributing to deat	n but not res	ulting in the u	nderlying ca	use give	ın in Part I.		23e. Did toba	icco use contril	oute to the cause of	death?
Records,	·= 0 10	ed by									1 🗌 Yes	2 □ No 3	3 ☐ Probably 4	Unknown
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Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Otho		of Death (C	heck only one	)		
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ion	Attending r death. ector: After y the fune	atlor	1 Natural 5 Pending 2 Accident investigation	(Month,	Day Year)	Injury	М	3c. Injury Work	:? ′es 2 🗆 I			injury coccino	<b>-</b>	
Division of	r Atte	Certification;	3 ☐ Suicide 6 ☐ Could not determined		Injury - At ho	ome, farm, str	eet, factory,	office		28f.	Location (Stre City or Town,	et and Number State)	r or Rural Route Num	nber,
Ω	pital o urs af eral D illed ir	1 1										_		
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	edical	29a. Certifier 1 Certifying P (Check only one) 2 Medicel Exa	hysicien: To the be miner: On the basis and manner	s of examina	wledge, death tion and/or in	n occurred a vestigation,	it the tim in my op	e, date and inion, dea	d place, and th occurred a	due to the cau at the time, date	ise(s) and man e and place, ar	ner as stated. nd due to the cause(s	s)
	To the within To the compl	Me	29b. Signature and title of certifier	1			29c.	License	number				(Month, Day, Year)	
)			> //\ V					D	596	14		MARI	42005	
	2		30. Name and address of person who	S. BEM	of death (Item	n 23a) (Type,	Print)	16N	ES H	SPITE				TIMURĪ
	Sta	te	31. Date filed (Month, Day, Year)	32. Regi	strar's Signa		وع						,	

OBRIEN, IDA

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Pollard Dempsey rea! ack March 00:00a N 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Harbor Hospital Baltimore Center n/a 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) 1**∑**M 2□ F Director 216-12-8868 82 May 20 1922 North Carolina Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location show 10d. Inside City Limits the Medical Exeminer must be notified at Director Maryland Baltimore 1 ☐ Yes 2 ☐ No Halethorpe 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? ö "naturel", or Items 23s. 4410 Norfen Road 21227 United States Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1X Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ģ If Yes, Give Year or Dates: 1 ☐ Yes 2 € No Specify 3 ₩idowed 4 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7; Department of Health and Mental Hyglene. Importent: If item 27 is marked other than "na any injury or other freumatic event, tre Medic once. Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6 Steamfitter U.S. Government 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Willie Pollard Dora Rose Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernice E. Lancaster / Daughter 4409 Norfen Road, Halethorpe, Maryland 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Surial 2 ☐ Cremation 3 ☐ Removal from State Donation 5 Other (Specify) Meadowridge Mem. Park 3/25/2005 Elkridge, Maryland 22. Name and Address of Facility 21. Signature of Fyreral Service Licenses Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician neumonia /Medical Due to (or as a consequence of) one week Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury 2 Months Physician/Medicai Examiner The law requires that the death certificate be executed **Durial-transit** Tract Due to (or as a consequence of) that initiated events resulting in death) Last Box 68760, Sicien absce the asi IF FEMALE use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Year 4 Pregnant at time of death 5 Other (specify) P.O. | ☐Yes 2☐No detached 9☐ Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by pe Vephrolithiasis 2 should 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has autopsy performed Yes 2 funeral director, page 1 Yes or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending investigation Injury within 24 hours after death. To the Funerel Director: A 1 Tyes 2 No the 2 Accident 6 Could not be determined 3 Suicide in by 1 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifie 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) hallah MD P18437BPQA Murch, 22, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type. Print)

Ahmad Mahallati, 3001 South Hanover St., Baltimore, MID, 21225 . Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar MAR 24

			For State		epartment of Health and I	/		)
	Physici	an	Registrar  1. Decedent's Name (First, Middle, La		Continuate of Beating	2. Date of Death Month Day	3. Time of Death	
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Ė	Funeral Director		5. Social Security Number 6. S	C 1 - 1 2	hday) If Under 1 Year Munder 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Forei	gn
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	or Location		10d. Inside City Limi	ts
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	with th	Funerai Director	3933 PINE	DOLEDO	10f. Zip Code	10g. Cit	izen of What Country?	
	r death	ınera	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl	pecify Yes or No-	14. Race - American Indian, Black, White, etc.	۷_
036	72 hours after death with the Maryland natural', or Itams 23s or 28s-f show Alcal Examiner must be notified at	by	1 ☐ Never Married 2  Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify: WHITE	
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212	giene.	Somp	Elementary/Secondary (0-12)	College (1-4or 5+)	ALES PERSON	co	NTRACTING	
and	nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan arthrent of Heatth and Mental Hygiene. ortant: if Item 27 is marked other than "natural", or Itams 23s or 28a-f show Injury or other traumatic event. It would Examiner must be notified at 9.	Be	17. Father's Name (First, Middle, Last	ICKER	18. Mother's Nar	ne (First, Middle, Maiden	Surname)	
Maryland	2 should be and Mental is markad sumatic ev	Το	19a. Informant's Name/Relationship		Mailing Address (Street and Number or Re	ural Route Number, City o	or Town, State, Zip Code)	
-	1 and Health tem 27		20a. Method of Disposition	L/SPOSE 9 20b. Place of	Disposition (Name of	R. NOTTA Date 20c. Lo	CHAM ND 212 Ocation - City or Town, State	34
Baltimore	Pages nent of ant: if it ury or o		1 ☐ Burjal 2 ☐ Cremation 3 ☐  4 ☑ Donation 5 ☐ Other (Speci	JHemoval from State	y, crematory or other place)	20/05 HF	ANOVER MD	
Balt	permit. Pag Department Important: t any Injury o		21. Signatura of Funday Service Lice	ns	22. Name and Address of Facility	uneral Home And Cre	mation Center, P.A.	
	7		23a Part1. Enter the disease, of one shock or heart failure. I st only	plications that caused the death. Do n		in Road - Pasadena		
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a HYPERKA	LEMIA		Onset and Death  1 WEEK	<
	Examiner			Due to (or as a consequence of	TIC CANCE	ER	9 MOST H	5
/	ted .	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of			1 119011	
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38760,	icate be physici s the bu	dical		d				
Box 6	death certific e attending p id for use as	an/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	3 □Ectopic pregnancy		23d. Date of delivery	
ю. В	0 0	Physician/Medical	in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	4 Pregnant at time of death	5 ☐ Other (specify)		Month Day Year	
s, P.	uires that the signed by th d be detache		Part II. Other significant conditions	contributing to death but not resulting in	, ,	23e. Did tobacco u	use contribute to the cause of death?	
ord	requ neen	eted	PROUSSEAU	'S SYNDROM	<u> </u>	1 ☐ Yes 2		
Vital Record	e lav has	ompieted by				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No	
/ital	ysician: Th is certificate director, pag	Be C	25. Was case referred to medical examiner?			1 ☐ Yes 2 X No ath (Check only one)	1 1 1 1 1 2 1 1 1 1 1	
of	g .s .g	. To	1 ☐ Yes 2/X No  27. Manner of Death	Hospital: 1 ☐ Inpatient 2 ☐ ER/Ou  28a. Date of Injury 28b. T	tpatient 3 DOA Other: 4 Nursing Fine of 28c. Injury at	lome X Residence 28d. Describe how injur		_
ion	Attending in death. actor: After by the funer	ation	Vatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) In	M 1 Yes 2 No	Zed. Describe now injur	y occurred	
Division	il or Attend after death Diractor: /	Certification:	3 Suicide 6 Could not I 4 Homicide determined		rm, street, factory, office	28f. Location (Street an City or Town, State	d Number or Rural Route Number, )	
	Hospita 4 hours Funeral ely fille	edicai C	(Check only 2 Medical Exa	miner: On the basis of examination and	, death occurred at the time, date and place	a, and due to the cause(s)	and manner as stated. If place, and due to the cause(s)	
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)	10		, 0 // -	completed cause of death (Item 23a) (Item 23a) (Item 23a)	RES-OOC Type, Print) ORTH WOLFE STREET	- RAITELLED	21, 2005 21231	
	C Sta		, 0 // -		ORTH WOLFE STREET	BALTEMORY	H 21, 2005 21231 EMARYLAND	

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year Pulliam 2005 March 21 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BAITMERS HOSPITAL If Under 1 Year | if Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 D **Funeral** Days 1□M 3€F 18 4556 Director Usual Residence of Decedent ould be filed within 72 hours after death with the Maryland Mental Hygiene. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?? is marked other then "natural", or Iteme 23e or 28e-f show traumatic event, the Modical Examiner must be notified at Director 1; ☐Yes 2 ☐ No BAHMURE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21218 4.5.12 Completed by Funeral 60rsuch 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 ☑ Widowed 4 □ Divorced Black 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) REFORT HUPKINS HUSPITER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be ment of Health and Menta tant: If Item 27 is marked Johnson VIOLA Smith NORTH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darbora Shields 1517 MO Gersuch BAITMOIS other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If It any Injury or o 1 Burial 2 Cremation 3 Removal from State ^ 4 ☐ Donation 5 ☐ Other (Specify) BAILMORY MD GAMISON 22. Name and Address of Facility BEAS Funeral 21. Signature of Funeral Service Licensee Votucia Bus St BALTIMUIE MD 21213 1129 N. Caroline 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one capse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to for as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner to (or as a consequence of) The law requires that the death certificate be executed use as the burial-transit been signed by the attending physicien and should be detached for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Cher (specify) 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3 DQA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred after death. Director: After 1 SNatural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel o within 24 hours af To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Nem 23a) Type. Frin 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

**ORIGINAL** 

amend item#18, perFH, G841, 3,24/05 TT State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day March 18 2005 **Physician** Irene M. Quinn 7:01 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Towson Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) Months Days Hours 1 M 2 F Sept. 12 1926 PA <u>213-20-6865</u> 78 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☐ No MD**Baltimore** Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 208 Solway Rd. 21093 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: ģ Specify: 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 n/a Bookkeeper **Broadway Tailoring** 18. Mother's Name (First, Middle, Maiden Sumame) Helen Zone Eielen Sone 17. Father's Name (First, Middle, Last) Be

208 Solway Rd.,

Garrison Forest Veterans Cem.

22. Name and Address of Facility

20b. Place of Disposition (Name of cemetery, crematory or other place)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3/25/05

7801 York Rd., Towson, MD 21204

Timonium, MD 21093

20c. Location - City or Town, State

Garrison Forest, MD

Physician /Medical

permit. Pages 1 and 2 should be filed v
Department of Health and Mental Hygie,
important: if item 27 is marked other it
any injury or other traumatic event, tills

n and Mental Hygie

Joseph Shinsky 19a. Informant's Name/Relationship (Type, Print)

4 □ Donation 5 □ Other (Specify)

20a. Method of Disposition

Eugene T. Quinn/husband

1 XBurial 2 ☐ Cremation 3 ☐ Removal from State

of Fuperal Service Cicenses

rug 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Timothy Doyle, M.D.

MAR 2 4 2005

31. Date filed (Month, Day, Year)

Examiner

**Funeral** 

Director

in than "natural", or itema 23a or 28a-f show the Wedleal Exercitive must be notified at

filed within 72 hours after deeth with the Maryland

Baltimore, Maryland 21215-0036

ed by the e

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

	iry				Timonium	n, MD 2	1093
23a. Part1. Enter the disease, or com shock, if heart failure. List only Immediate Cluse Final disease or condition	one cause on ach line.		mode of dying, si			>	Approximate Interval Between Onset and Death
resulting in death)	Due to (or as a conse		70				
Sequentially list conditions, if any, leading to inniediate cause. Enter Underlying Cause (Disease or injury	b. Oue to (or as a conse	quance oi).					
that initiated events resulting in death) Last	c.  Due to (or as a conse	quence of):					
If FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Ny. 10	23c. If yes, outcome of pregr 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3 Ector	oic pregnancy or (specify)			23d. Date of de Month	livery Day Year
Part II. Other significant conditions	contributing to death but not re	sulting in the underly	ing cause given in	Part I.	23e. Did tobacco		o the cause of death?
					24a. Was an autopsy performed?	death?	utopsy findings availab completion of cause o
25. Was case referred to medical examiner?				. Place of Dea	th (Check only one)		
1 ☐ Yes 2 No	Hospital: 1 Mnpatient 2	ER/Outpatient 3	DOA Other:	Nursing H	ome 5 Residence	6 ☐Other (Spe	cify)
27. Manner of Death  1 Xatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	2 🗆 No	28d. Describe how inj		
3 ☐ Suicide 6 ☐ Could not be determined		nome, farm, street, fa	ictory, office		28f. Location (Street a City or Town, Sta	ind Number or Ri te)	ural Route Number,
27. Manner of Death  1 Matural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  29b. Signature and title of certifier	hysician: To the best of my kn minar: On the basis of examin and manner stated.	owledge, death occu ation and/or investiga	irred at the time, d ation, in my opinio	late and place n, death occu	, and due to the cause( rred at the time, date at	s) and manner as nd place, and due	s stated. a to the cause(s)
29b. Signature and title of certified			29c. License nu	mber	29d. D	ate signed (Mont	h, Day, Year)
<b>)</b>	whe		D 50	2859	M	arch z	1, 2005

DHMH 17 Rev 1/2001

State

Registrar

37 Registrar's Signature

		1 - For State Registrar	State of Maryland / Dep	partment of Health and ertificate of Death	Mental Hygie	4000 10054		
		1. Decedent's Name (First, Middle, Last)				3. Time of Death		
Physicia /Medic		Hailey	Marie	Ruffa	2. Date of Death	Day 21 2005 10:33 Q.M		
Examin		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Deat		4c. County of Death		
		Franklin Squar	e Haspital	Rose dale		Baltimore		
Funeral		5. Social Security Number 6. Sex	3 1 3	If Under 1 Year If Under 24 Hrs	8. Date of Birth	9. Birthplace (State or Foreig		
Director		N/A	M 2XF Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye March 21	,2005 MD.		
P .		Usual Residence of Decedent						
anyia	_	10a. State 10b. County	10c. City, Town or I			10d. Inside City Limits		
Ba-f	cto	MD N/A	Baltimo	re		1X Yes 2 □ No		
or 2	Dire	10e. Street and Number		10f. Zip Code	1	Citizen of What Country?		
be filed within 72 hours after death with the Maryland tal Hygjene. d other than "naturel", or iteme 23s or 28s-f show event, it a Medical Exertal extransities rediffed at	Funeral Director	5032 Erdman Avenue		21205		USA		
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s afte	by Fi	1 Never Married 2 Married	1 ☐ Yes 2 🖄 No If Yes, Give	1 ☐ Yes 2X No Specify:		Specify: White		
hour urei'	d b	3 Widowed 4 Divorced	Year or Dates:		1			
"nai	Completed	15. Decedent's Edu (Specify only highest grade	completed) (Giv	edent's Usual Occupation re kind of work done during most of wo DO NOT use retired)	rking 16t	b. Kind of Business/Industry		
withii ane. than	E G	Elementary/Secondary (0-12)	College (1-4or 5+)			N/A		
filed Hygi ther		N/A  17. Father's Name (First, Middle, Last)		N/A	me (First, Middle, Maid			
d be ontal	Be c	David Ruffa			nie Everha			
thout od Me mark mati	은	19a. Informant's Name/Relationship (Ty	ne Print) 19h Mai	ling Address (Street and Number or R				
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Inspectment of Health and Mantal Hygiene. Inspectment of Health and Med Hygiene.  Inspectment: If term 27 is marked other than "naturel; or iteme 23a or 28a-f show any injury or other traumatic event, tra Medical Exarca retinual by Inclifical at 2008.		Stephanie Everhart		Erdman Avenue, B				
1 an Heal Hem 2 ther		20a. Method of Disposition	20b. Place of Disc			: Location - City or Town, State		
ages nt of nt of		1 <b>X</b> uriai 2 ☐ Cremation 3 ☐ F	emoval from State		sh 26,	undalk		
it. P.	1 1	<ul> <li>4 □ Donation 5 □ Other (Specify)</li> <li>21. Sigpettine of Funeral Service License</li> </ul>		the contract of the contract o	,05			
permit. Pages 1 ar Department of Hea Important: if Item any injury or othe once.		the thomas	- (/ 1/.	22. Name and Address of Facility Connelly Funeral	Home Of Du	ndalk, P.A.		
		23a Parti Enter the disease of compli		7110 Sollers Poin				
			cations that caused the dead. Do not ele cause on each line.		or respiratory arrest,	Interval Between Onset and Death		
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		moturity				
Examiner			Due to (or as a consequence of):	1 - 1 - 1				
	-	Sequentially list conditions,	Chorioamr	110nitis				
be is	lne	if any, leading to immodiate cause. Enter Underlying Cause (Disease or injury	- Death (of as a consequence of):					
xecul and II-trar	Examiner	that initiated events resulting in death) Last	Due to (or as a consequence of):					
ficate be executed physician and is the burial-transit	aiE							
icate phys s the	dicai							
eath certif attending for use a	/Me	IF FEMALE:	3c. If yes, outcome of pregnancy		- 1111	02d Date of delivery		
atten for u	clan	in the past 12 months?	1 Live birth 2 ☐ Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery  Month Day Year		
the d	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	□ Ottlei (specify)				
The law requires that the death certifial has been signed by the attending bage 2 should be detached for use as	by Physician/Me	Part II. Other significant conditions con	tributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobaco	co use contribute to the cause of death?		
uires t signe					1 ☐ Yes	2 No 3 Probably 4 Unknown		
he law requir e has been si age 2 should I	Completed				240 1460 00	Oth Man a transfer finding and the		
The lav	ш				24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?		
					1□ Yes 2X	No 1 ☐ Yes 2 ☐ No		
Physician: r this certifica ral director, p	Be	25. Was case referred to medical examiner?	lospital: 🔏	Othor	ath Check onl one			
	To	1 Yes 2 No	ospital: 1 Inpatient 2 ER/Outpatient 28a. Date of Injury 28b. Time	HIL 3 DOA 4 Nursing P		6 Other (Specify)		
I or Attending Phy after death. Director: After this in by the funeral d	lon	1 Natural 5 ☐ Pending	(Month, Day Year) Injury	Work?  M 1 □ Yes 2 □ No	28d. Describe how i	njury occurred		
deatl deatl ctor: / the	Certification:	2 Accident investigation 3 Suicide 6 Could not be	290 Place of Injury. At home form of		28f Location (Street	t and Number or Rural Route Number.		
i or Attsnr after deatl Director: I in by the	ertif	4 Homicide determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, ractory, office	City or Town, Si			
Hospital 24 hours a Funeral i		29a. Certifier 1X Certifying Phys	rician; To the best of my knowledge, de-	ath and and at the first data and also		-/		
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	edical	(Check only 2 Medical Examinations)	sician: To the best of my knowledge, dea ner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occu	e, and due to the cause urred at the time, date	ण्डा बाव manner as stated. and place, and due to the cause(s)		
To the Within 2 To the complet	Med	29b. Signature and title of certifier		29c. License number	29d.	Date signed (Month, Day, Year)		
⊬ ≯ ⊢ ŏ		20.	ore Cheece			03. 21. 2005		
			1	Kes 0000				
2		Dr. T. S. S. C.	mpleted cause of death (Item 23a) (Type	O Franklin So	nia D	Baltimore MD 21237		
Sta	to	31. Date filed (Month, Day, Year)	32. Pogistrar's Signature	o rightill .	one inve	Dattinore MD 21231		
- 310	ar		105 Brown & A	marke 3				

Babygirl Everhart

			1 - State of Marylan		artment of Health and I		ene 005   0045
	Physici /Medic		1. Decedent's Name (Eirst, Middle, Last)  1. Recedent's Name (Eirst, Middle, Last)	- Rt	ED	2. Date of Death Month	Day Year 23.105
	Examin Funeral Director		4a. Fecility Name (If not institution, give street and number)  LAUREL REGIONAL HOSPITAL  5. Social Security Number  414-24-4636  6. Sex 1 M 2 K F 7. Age (In yrs. 85)	last birthday) Yrs.	4b. City, Town, or Location of Death LAUREL  If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth	4c. County of Death PRINCE GEORGES  9. Birthplace (State or Foreign Country) NORTH CAROLINA
			Usual Residence of Decedent         10a. State         10b. County         10c. Cit	ty, Town or Lo	cation	12-26-19	919 NORTH CAROLIN  10d. Inside City Limit
	th the Mar or 28e-f st	Director	MD PRINCE GEORGES LAUR  10e. Street and Number	.EL	10f. Zip Code	10	1 ☐ Yes 2 📉 N
	23a ust b	ai	8720 OXWELL LANE		20708		USA
036	72 hours after death with the Maryland netural', or items 23a or 28e-f show acel Examiner rust be motified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Notice 4 Divorced  12. Was Decedent Ever in U Armed Forces?  1 Yes 2 Notif Yes, Give Year or Dates:	1	Was Decedent of Hispanic Origin? (Sif Yes, specify Cuban, Mexican, Puerton 1 Yes	pecify Yes or No- p Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: WHITE
21215-0036	d within 72 hours piene. r then "netural",	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	(Give	dent's Usual Occupation kind of work done during most of wor DO NOT use retired)	king 1	6b. Kind of Business/Industry
and 2	be filed atal Hyg ad othe event,	To Be Co	12 17. Father's Name (First, Middle, Last) ARCH BENNETT	HOUS	EWIFE  18. Mother's Nam  MAE MCKE	ne (First, Middle, M	HOMEMAKER laiden Sumame)
Maryland	d 2 shouth and 17 is m	ř	19a. Informant's Name/Relationship (Type, Print) SHARON MCCARTHY/DAUGHTER		ng Address (Street and Number or Ru OAK LEAF LANE FAY	ral Route Number,	
Baltimore,	permit. Pages 1 an Department of Heal Importent: If item 2 any njury or other once.		20a. Method of Disposition  1 XBurial 2 Cemation 3 Removal from State  4 Donation 5 Other (Specify)  21. Signatur F heral Selvice Licen  MO 1	Place of Disponent Complete, Crem BERLAN DENS	sition (Name of	CH 25 FA	Oc. Location - City or Town, State AYETTEVILLE, N.C.
	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the deat shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)			(	GLEN BURNIE, MD 2106
	Examiner	_	bue to (or as a conseq	neuca off.	ASPIRAT (C	731	VORYS
<u> </u>	be executed sician and burial-transit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	PRIE	THE STROK	E.	7day)
68760,	ificate be g physicia as the bur	edicai	CoRight M	TERN,	AL CAPOTIDAR	TERY OF	nsivercy
.O. Box	at the death certificate by the attending phys tached for use as the	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown  23c. If yes, outcome of pregnat 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	ıl death 3 ☐	Ectopic pregnancy	<u></u>	23d. Date of delivery Month Day Year
cords, P	requires the	by	Part II. Other significent conditions contributing to death but not res	ulting in the ur	nderlying cause given in Pat I.	1 - Yes	
Vital Record	The lar ate has page 2	Be Completed	PI ASTVO ESCHUNGENO  5. Was case referred to medical examiner?	Rt	SFL UX 26. Place of Dea	24a. Was an autopsy perform 1 Yes 2	prior to completion of cause of death?  No 1 Yes 2 No
of	ding Phys h. After this funeral di	2	Hospital:	ER/Outpatien 28b. Time of Injury	28c. Injury at Work?  M Other: 4 Nursing H	ome 5 Resider 28d. Describe hov	nce 6 Other (Specify) w injury occurred
Division	in the	Certification;	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At he building, etc. (Specification)	ome, farm, stre		28f. Location (Str. City or Town,	eet and Number or Rural Route Number, State)
	o the Hospitel thin 24 hours a the Funerel empletely filled	Medical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my kno 2 Medical Examiner: an the basis of examina and manner stated.	wledge, death tion and/or inv	o occurred at the time, date and place vestigation, in my opinion, death occur	rred at the time, da	use(s) and manner as stated. te and place, and due to the cause(s)

To the Hospital or Atte within 24 hours after ded To the Funeral Directo completely filled in by th

completed cause of death (Item 23a) (Type, Print)

TRUS PD - 143009ALIANT FOXLAFICZ BOWIE PD

122. Registrar's Signature posts

State

Registrar

29d. Date signed (Month, Day, Year)

3/20/05

			1 For State Registrar	State of M	Maryland / Depa <i>Cei</i>	artment of H		d Mental Hy	gierre ()	5 10046
			Decedent's Name (First, Middle, Last	)				2. Date of De	aath	3. Time of Death
	Physici /Medio		MARY C. SCOTT					MARCH	19, 2005	Year 1:58 P M
	Examin		4a. Facility Name (If not institution, give	street and number	r)	4b. City, Town, or	Location of D		4c. County	
			1207 KENWOOD RD			GLEN BU			ANNE	ARUNDEL
	Funeral Director		5. Social Security Number 6. Se 1[	X 2 F 7. A	Age (In yrs. last birthday)  Yrs.	If Under 1 Year Months Days	If Under 24 H	8. Date of Bir (Month, Da FEB 16	ay, Year)	Birthplace (State or Foreign Country)     MD
	pu 🔭		Usual Residence of Decedent  10a, State 10b, County		10c. City, Town or Lo	cation				10d. Inside City Limits
	shor	2								
	28a-f	Director	MD ANNE ARI  10e. Street and Number	NDEL	GLEN B	10f. Zip Code			10g. Citizen of V	1 Tes 2 No
	with							i		
	ss 23	era	1207 KENWOOD RD  11. Marital Status	12. Was Deceder	at Ever in II S 13 )	21060	ispanic Origin?	(Specify Yes or No		JSA e - American Indian,
36	hin 72 hours after death with the Maryland B. "natural", or items 23e or 28e-f show Medical Examinar must be notified at	by Funeral	1 Never Married XXMarried 3 Widowed 4 Divorced	Armed Forces  1  Yes XX  If Yes, Give Year or Dates	No	f Yes, specify Cuba	Specify:	(Specify Yes or No perto Rican, etc.)	Specify	ck, White, etc.
Ö	thou stura	eq	15. Decedent's Edi	cation	16a. Deced	dent's Usual Occupa	ation		16b, Kind of Bu	usiness/Industry
21215-0036	n "nat	Completed	(Specify only highest grad Elementary/Secondary (0-12)	le completed) College (1-40)	life. I	kind of work done of DO NOT use retired	during most of d)	working		,
212	d wil	E	10	College (1-40)	WAIT	RESS			FOOD S	SERVICE
	be filed Ital Hygi Id other	Bec	17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Middle		
lar	should be nd Mental marked c	ToE	LEWIS BOYER				LILLIA	N ROTH		
Maryland	and and sum	•	19a. Informant's Name/Relationship (T	/ρθ, Print)				Rural Route Numb	-	·
	1 and 2 Health tem 27		LEO T. SCOTT	HUSBAN			RD GLE	N BURNIE,	MD 2106	51
altimore,	00 0		20a. Method of Disposition  XXBurial 2 ☐ Cremation 3 ☐	Removal from Stat	20b. Place of Dispo	sition (Name of natory or other plac	ce)	Date	20c. Location -	City or Town, State
<u>Ē</u>	permit. Pages Department of Importent: If it any injury or o		`4 ☐Donation 5 ☐ Other (Specify,		GLEN HAV	EN CEM	3.	23.2005	GLEN B	BURNIE, MD
<u>a</u>	permit. Pag Department Importent: any njury c		21. Signal, a of Fineral Service Lic-ni	99 0		. Name and Addres			6 CRAIN	
8	82589		K. GREGOLY FI	K MO	1148 F1	NK FUNERA	AL HOME	, P.A. GL	EN BURNI	E, MD 21061
	/Medical Examiner	niner	if any, isacing to immediate cause. Enter Underlying Cause (Disease or injury	b. —A	is a consequence of):	c ca	ass	Prin	Coj.	onset and Death
Box 68760,	d ath certificate be executed e attending physician and of for use as the burial-transit	Physician/Medical Examin	230. Was decedent program	d	2 Fetal death 3	Ectopic pregnancy			23d. Dat	te of delivery
0	the d	ysic	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4 □ Pregnant 9 □ Unknown		Other (specify)				
<b>Q</b>	that ed b	by	Part II. Other significant conditions co	ntributing to death	but not resulting in the u	nderlying cause give	en in Part I.	23e. Did t	~ /	ribute to the cause of death?  3 Probably 4 Unknown
Vital Records,	e la has e 2	Completed						24a. Was auto perfo 1 Yes	psy prmed?	Mere autopsy findings available orior to completion of cause of death?
ita	ien: The	Bec	25. Was case referred to medical				26. Place of I	Death (Check only o	one)	
<u></u>	Physicien: this certific al director,	70 [	examiner? 1 Yes 2 No	Hospital: 1 □ Inpa	tient 2 ER/Outpatien	it 3 DOA	er: 4 🗆 Nursin	g Home Kesi	dence 6 Othe	er (Specify)
ion of	ding After funer		27. Manner of D→th Natural 5 ☐ Pending a ☐ Accident investigation	28a. Date of In (Month, E	jury 28b. Time of Injury	Worl	yat k? Yes 2.⊡No	28d. Pescribe	how injury occurr	red
Division	tel or Attents after deatl	Certification:	B Suicide 6 Could not be 4 Homicide determined	28e. Place of I building,	njury - At home, farm, str etc. <i>(Specify)</i>	eet, factory, office		28f. Location ( City or To		er or Rural Route Number,
	To the Hospitel or At within 24 hours after of To the Funerel Directompletely filled in by	edical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	sician: To the besiner: On the basis and manner:	st of my knowledge, death of examination and/or in- stated.	occurred at the time vestigation, in my of	ne, date and pl pinion, death o	ace, and due to the courred at the time,	cause(s) and ma date and place, a	anner as stated. and due to the cause(s)
	To the H within 24 To the F complete	×	29b. Signature and title of certifier	rl	١ . ٨	29c. License	e number		29d. Date signed	(Month, Day, Year)
			Kong Ir	~ V		1	> 391	045	Man	ch 212005
	5)		30. Name and address of person who co	ompleted cause of	AAAA	Print) 300	olo S	11 Har	Lori	of street
			31. Date filed (Month, Day, Year)	A Ranis	strar's Signature		150	mino	7	1 21225
	Sta Registr		MAR 2 4 2005	Glecke	I See	K				

			1 - For State Registrar	State of	Marylar		artmen <i>rtificat</i>			and M	lental Hyg	giene Reg. No. ()	05	10047
	Physici	an	Decedent's Name (First, Middle, Landson Parks)								2. Date of Dea	ath Day	Year	3. Time of Death
	/Medic Examin		ARNOLD G. 4a. Facility Name (If not institution, gi		ber)		4b. City,	Town, or	Location of	of Death	MARCH	4c. Cour	2005 hty of Death	3,004
			ROCK GLEN NUR					LTIMO			_		/A	
H	Funeral Director		213-26-1498	Sex 【XIM 2□F		last birthday) 75 Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Birtl (Month, Day DEC. 16	r, Year)		lace (State or Foreign try) RYLAND
	land		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation						1	Od. Inside City Limits
	a-f sh	ctor	MARYLAND N/	A		BA	LTIMOE	RE						1 X Yes 2 ☐ No
	or 28	Director	10e. Street and Number				10f. Zip	Code				10g. Citizen o	of What Coun	itry?
	eath w	erai	107 S WICKHAM	ROAD 12. Was Deced	lant Evar in III	10 12	Was Doos	2122		min 2 /Cnc	noify Vac or No.	U.S	. A . ace - Americ	an Indian
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If itiem 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Madical Examiner must be notified at once.	by Funeral	11. Marital Status  1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Ford  1 Yes 2  If Yes, Give	es? ?[∑]No		If Yes, spec		Specify:	giii? (Spe i, Puerto	ecify Yes or No- Rican, etc.)		lack, White, or	etc.
Maryland 21215-0036	72 hou nature	ted	15. Decedent's E (Specify only highest gr	ducation		16a. Dece	dent's Usua	al Occupa	tion	of worki	na	16b. Kind of	Business/Inc	dustry
2	han r	Completed	Elementary/Secondary (0-12)	College (1-	4or 5+)		kind of wor DO NOT us	se retired)	uring most	OI WOIN	rig			
2	filed v Hygiei ther ti		3rd grade  17. Father's Name (First, Middle, Las	•)		N/A			18. Mothe	r's Name	(First, Middle,	N/		
aŭ	and be fental rked o	To Be	JOSEPH SCOTT	,						nown	(, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		a,,,,,	
lary	2 shot and N Is ma		19a. Informant's Name/Relationship	Type, Print)		19b. Maili	ng Address	(Street a			l Route Numbe	r, City or Tow	m, State, Zip	Code)
e, ≤	1 and 1ealth nm 27 thar tr		RoBin Jones/Daug	ghter	20h F	107 Place of Dispo			m Rd		altimor			
Baltimore,	ages int of h t: If its y or of		1 ☐ Burial 2 ☒ Cremation 3 [  '4 ☐ Donation 5 ☐ Other (Special Control of Co		ate	cemetery, crea	matory or o	ther place				20c. Location		
ᄩ	mit. P partme sortan Injur		21. Signature of Funeral Service Lice		ME		2. Name an	d Addres	s of Facility					MARYLAND
<u>~</u>	permi Dapa Impo any Ir		Darbara (	/_	,		VILLIA L206 V	AM C V NOF	BROW!	N COI VENU	MMUNITY E	FUNER.	AL HOM	E P.A.
ļ	Physician /Medical Examiner	iner	23a/Pant. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a. Due to to	ch line.  2000 c  r as a consequence  be 1	- 0	sion	Ca	rdio	Va	scular		rasi	Approximate Interval Between Onset and Death
O. Box 68760,	The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical Examin	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	d23c. If yes, outco	h 2⊡Feta ntattime ofd	ancy	Ectopic pro	egnancy	tu				Date of deliver	ry Day Year
Р.	res that the de signed by the a I be detached f	/ Phy	9 ☐ Unknown  Part II. Other significant conditions			ulting in the u	nderlying ca	ause give	n in Part I.		23e. Did to	bacco use co	ntribute to the	e cause of death?
rds	w requires been sign should be	ed by	Renal	ailu	rf						1 🗆 Y	es 2 No	3 ☐ Proba	ably 4 Unknown
		Completed									24a. Was a autops perform	Sy	prior to con death?	psy findings available apletion of cause of
Vita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				0.1		of Death	(Check only or	16)		
ō	ding Physician: The n. After this certificate h funeral director, page	2	1 Yes 2 No	1 🗆 In		ER/Outpatier 28b. Time o			4 (Merryur		ne 5 🗆 Reside			)
on	nding Phy ath. r: After thi e funeral (	atlor	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of (Month)	Day Year)	Injury	м	Bc. Injury Work 1 🔲 Y	? es 2 □ N			,,		
Divis	al or Attendes safter death	Certification;	3 ☐ Suicide 6 ☐ Could not t 4 ☐ Homicide determined	28e. Place C	f Injury - At ho g, etc. (Specif	ome, farm, str	eet, factory	, office		2	28f. Location (Si City or Town		nber or Rural	Route Number,
	To the Hospital or Attending Physician: within 24 hours after death To the Funaral Director: After this certifica completely filled in by the funeral director,	Medical (	29a. Certifier 1 Certifying P. (Check only one)	nysicien: To the bas miner: On the bas and manne	is of examina	owledge, death	n occurred a vestigation,	at the time in my op	e, date and inion, deat	d place, a	and due to the co	ause(s) and nate and place	nanner as sta , and due to	ated. the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	eran				License		6		9d. Date sign		
					of do-15 (1)	- 00-1 7	0	リム	64	7		with	det.	2005
	1		30. Name and address of person who AMBAWAA (**) 31. Date filed (Month, Day, Year)	BASKAK	of death (Item	1455	Wil	kei	91	AUT (	Bal	timo	L, M	2005
	Sta Registr	-	MAR 2 1 200	67	M	hoos	A. B							

State of Maryland / Department of Health and Mental Hygienen 1 - For State Registrate Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month AMBURD March 24, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner <u>Ashleigh's</u> Place Columbia Howard 5. Social Security Number 105 - 24 - 2952 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) New York **Funeral** 1 M 200 82 Yrs 01/31 /1923 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Exeminer must be notified at 1 Yes 2 No Director Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 21045 **USA** 6914 Spinning Seed Funeral "naturef", or items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No δ Specify 3 ☐ Widowed 4 X Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "na any injury or other traumatic event, Ite Mazic 2008. Elementary/Secondary (0-12) College (1-4or 5+) Clothing Industry Buver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Tony Vassallo Angelina Russo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Mitchell/Daughter 6914 Spinning Seed Columbia, MD 21045 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 3/25/05 Baltimore. MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation Society of MD, Inc. Thomas Gregor 299 Frederick Road Baltimore, 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HOURS **Physician** 140 CARdin /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transif atfending physician and for use as the burial-trar Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical the the use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the at d be detached to 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? cerfificate 1 🗌 Yes 2 2 🗆 No Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Assisted 1 Yes 2 No ို this To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury courred Certification; 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of centile 29d. Date signed (Month, Day, Year) 29c. License number 3-24-05 1)36786 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jethey 12 M.D., 606 Hamneds ( 14m2 M.D., 606 Hamminds Lane, L-2, Brooklyn Park, MD 21225 32 Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 2 1 2005 Registrar

		For State Registrar		rtificate of Death		eg. No2 0 0 5	1004
Physici /Medio Examin	al	1. Decedent's Name (First, Middle, Last,  JOHN  4a. Facility Name (If not institution, give  JOHNS HOPKINS BAYVIE	street and number)	TROUPE  4b. City, Town, or Location of Deat  BALTIMBRE	MARCH	Day Year 19 2005  4c. County of Deat  N/A	
uneral irector		5. Social Security Number 214–16–8433 6. Security Number 12	x 7. Āge (In yrs. last birthday)  N 2□ F 83 Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min.		2,1921 9. Birti 2,1921 MC	hplace (State or Fore untry) ).
ia-f ehow	ctor	Usual Residence of Decedent           10a. State         10b. County           MD         Baltimor	re Dundal				10d. Inside City Lin 1 ☐ Yes 2 [X
23a or 28 at be no	Funeral Director	10e. Street and Number 211 St. Helena Ave	enue	10f. Zip Code 21222	1	iog. Citizen of What Co USA	untry?
od other than "natural", or leans 23s or 28s-f ebov event, the Medical Examinat must be notified at	þ	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	1 □Yes 2 NNo	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, White Specify: Wh	e, etc.
than "natur is Medical	Completed	15. Decedent's Edu (Specify only highest grad	de completed) (Give life.	dent's Usual Occupation kind of work done during most of wo DO NOT use retired)	rking	16b. Kind of Business/	
ie markad other than aumatic event, tra Ms	To Be Co	12 years 17. Father's Name (First, Middle, Last) Guy W. Troupe	Lens		me (First, Middle, I	Eyeglasses Maiden Sumame)	5
Item 27 ie marka othar traumatic	•	19a. Informant's Name/Relationship (Ty Frieda Troupe		ng Address (Street and Number or Ri St. Helena Avenue			
Important: if Item 27 is any injury or other tra		20a. Method of Disposition  1XX Burial 2 □ Cremation 3 □ F  `4 □ Donation 5 □ Other (Specify)	temoval from State	sition (Name of matory or other place) Marc Faith Cemetery 20	n 23,	20c. Location - City or Rosedale, MD.	Town, State
Imports any inju		21. Signature of Funeral Service Licens  Thomas	ications that caused the death. Do not entine cause on each line.	Name and Address of Facility Connelly Funeral 7110 Sollers Poin	Home Of I t Road, I	Dundalk,P.A Dundalk,MD.	21222
sicien and purial-transit	cai Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that indiated events resulting in death) Last	Due to (or as a consequence of):  APNEA  Due to (or as a consequence of).  LUCTILOBAY PNEU  Due to (or as a consequence of):	MONIA			
ed by the attending physicien detached for use as the buria	Physician/Medi	IF FFMAI F:	23c. If yes, outcome of pregnancy 1 □Live birth 2 □ Fetal death 3 □	□Ectopic pregnancy □ Other (specify)		23d. Date of deli Month	very Day Year
E 0	þ	Part II. Other significant conditions con	ntributing to death but not resulting in the u	nderlying cause given in Part I.		bacco use contribute to	
s certificete has been sig irector, page 2 should b	Completed				24a. Was a autops perford	med?   death?	topsy findings avai completion of cause
0	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 █ Inpatient 2 ☐ ER/Outpatier		ath <i>(Check only or</i> dome 5  Reside	ne) ence 6 □Other <i>(Spe</i> c	cify)
	Certification:	27. Manner of Death  1  Natural 5  Pending investigation  3  Suicide 6  Could not be	28a. Date of Injury (Month, Day Year)  28b. Time o	f 28c. Injury at Work?  M 1 □ Yes 2 □ No	28d. Describe ho	ow injury occurred	
To the Funeral Director: After completely filled in by the fune		4 Homicide determined	28e. Place of Injury - At home, farm, str building, etc. (Specily)		City or Town		
he Fun pletely	Medical		sician: To the best of my knowledge, deat ner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occi	urred at the time, d	ate and place, and due	to the cause(s)
<b>0</b> E	Σ	29b. Signature and title of certifier	_, M.D.	29c. License number <i>RES-000</i>		19d. Date signed <i>(Montl</i> March 19,	
i - ö		Cell -					

Angela Townes 05-1926 AKG

26			Chata of Mandand			
			1- For Unpend Item 23State of Maryland / State Registrar	Certificate of Death	tas  Reg.	2005 10050
	Physici		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month March 17	Day Year 8:28 A M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death Baltimore		4c. County of Death
	Funeral Director		1343 North Carey Street  5. Social Security Number  6. Sex  1 M 2 F 43		8. Date of Birth (Month, Day, Ye	ar) 9. Birthplace (State or Foreign
	D		Usual Residence of Decedent  10a. State 10b. County 1 10c. City, To	wn or Location	17 7- 69	10d. Inside City Limits
	death with the Maryland ms 23a or 28e-f show Litual be notified at	Director	MOI MA BAH	timoice		16 Yes 2 No
	ath with t 23a or 2 ust be n	ral Dir	819 SEREPER	2/205	109.	Citizen of What Country?
0036	hours after des turel', or Items al Exertiner m	by Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuber, Mexican, Puerto 1 ☐ Yes ☑ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: BIACK
N-C1717	be filed within 72 hours after death with the Marylan tal Hygiene. d other then "naturel", or items 23a or 28e-f show event. I're Medical Ereginer must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	a. Decedent's Usual Occupation (Give kind of work done during most of work life, DO NOT use retired)  A Sustain	ing 16b	Kind of Business/Industry  LICSUAGE  LOOP FA
yland		To Be C	17. Father's Name (First, Middle, Last) EACL TOWNES	Milchel	e (First, Middle Maid	WES
, Mar	nd 2 salth ar 27 is r treu		1411(114C) 1. 44111141113(ON) 17	D. Mailing Address (Street and Number or Rur 19 SATUKAN COURCE	111111111111111111111111111111111111111	1111,21254
Банттоге	Pa men ent: ury		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  21. Signature of Funeral Service Lipenshe	ery, prematory or other place)  3-2	01-05 B	Location - City or Town, State
מ	permit. Departi Import any inj		Chtha Y. Galmire	22. Name and Address of Facility 1302 N CHREA A	是科技	0.Md. 2/2021
	Pnysician	15 11	23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.  Immediate Cause (Final		or respiratory arrest,	Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)  Narcotic Intox  Due to (or as a consequence			
	ed sit	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	e of):		
9/00,	ate be executed hysician and the burial-transii	lical Examiner	that initiated events resulting in death) Last c Due to (or as a consequence d	9 of):		
O. Box 68	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the buriat-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown	th 3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year
cords, P	requires that een signed b hould be deta	by	Part II. Dther significant conditions contributing to death but not resulting Cocaine Use, Hypertensive Cardiovas			co use contribute to the cause of death?
Ţ	sicien: The law req certificate has been irector, page 2 shou	Completed	mellitus		24a. Was an autopsy performed	
VIII	sicien: certifica rector, p	o Be C	25. Was case referred to medical examiner?  1. TWes 2. The Hospital:	Othor	h (Check only one)	, ,
on or	ding Phys	Η,	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury Counterth, Day Year) Fo	Time of 28c. Injury at Work?  1 \( \superscript{Yes} \) 2 \( \superscript{X}\) No 2 \( \superscript{X}\) No	me 5 Residence 28d. Describe how in	and the second s
DIVISION	To the Hospitel or Attending Physicien: within 24 hours after death.  To the Funerel Director: After this certific completely filled in by the funeral director.	Certification:		farm, street, factory, office	28f. Location (Street City or Town, St Baltimore	and Number of Rural Route Number late) 1343 N. Carey Stree MD
	Hospit 24 hour Funera stely fille	Medical (	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination a and manner stated.	ge, death occurred at the time, date and place, and/or investigation, in my opinion, death occur	and due to the cause red at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year) [arch 17, 2005]
			30. Name and address of person who completed cause of death (Item 23a)			
	≸ Sta	te.	CAROL HALL N Md.  31. Date filed (Month, Day, Year) 32. Registrar's Signature	111 Penn Street Ba	ltimore,	Maryland 21201
3"	Registi		MAR 2 4 2005	100		

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene = For State Ragistrar Certificate of Death Reg. No 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Month / alentine **Physician** 10:50 PM March 18 2005 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltimore Johns Hopkins Hospital Baltimore If Under 1 Year | If Under 24 Hrs. 8. Months | Days | Hours | Min. 8. Date of Birth Feb. 18, Year) 945 5. Social Security Number '. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** Days 1 €M 2 □ F 538-52-7473 60 Washington Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Virginia Fairfax Fairfax 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 10922 Byrd Drive 22030 or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Tyes 2 No
If Yes, Give Victor Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married White n tes, Give Year or Dates: VietNam 1 ☐ Yes 2 No Specify: Specify þ 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. nt: If item 27 is marked other than rry or other traumatic event, the Ma College (1-4or 5+) Elementary/Secondary (0-12) 12 World Customs Org. Attorney 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Valentine ပ Angelo Louis Grace Marie Candee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cleosa E. Valentine (Wife) 10922 Byrd Drive, Fairfax, Virginia 22030 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Imports nt: if any inj.rry or once. \* 4 ☐ Donation 5 ☐ Other (Specify) Everly Funeral Home 3/22/05 Faifax, Virginia 22. Name and Address of Facility Everly Funeral Home 21. Signature of Funeral Service Licensee 10565 Main Street, Fairfax, VA. 22030 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician pneummia isteria 2 weeks /Medical Due to (or as a consequence of) **Examiner** cell leukmia retractory plasma -Vears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequent Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician ician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy perfor 1 🗌 Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ٥ 28a. Date of Injury (Month, Day 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Director: After 1 Natural 5 Pending investigation 1 Yes 2 No Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Kosalyn ( D60203 March 18, 2005 on ongen 30. Name an ddress person vit completed cause of death (Item 23a) (Type, Print) 1650 Orleans Street Johns Hopkins CRB-186 Baltimore, Maryland Rosalyn Juergens no 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend items 17, 18 per fin 88/2 4-5-05 vt.

Beautiful State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) WISER 2005 March P3Y ELNEZIA **Physician** 3:55 Рм /Medical 4a. Facility Name (If not institution, give street and number)
Holy Cross Hospital 4b. City, Town, or Location of Death Silver Spring 4c. County of Death Examiner Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11-07-1925 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Washington, DC 79 1 □ M 2)XX 577-40-8637 Director Usual Residence of Decedent 10c. City, Town or Location Hyattsville with the Maryland 10d. Inside City Limits 10b. County 10a. State 28a-f show traumatic event, the Medical Examiner must be notified at Prince George's MD XX Yes 2 ☐ No Director 10g. Citizen of What Country? 10f. Zip Code 20783 10e. Street and Number 6 1205 Raydale Court Itams 23a death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural, or Itam any injury or other traumatic event, the Medical Experiment ☐Yes XX No Yes, Give 1 Never Married Married Specify Black Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: þ If Yes, Give Year or Dates: 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) n/a School Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jackson Amanda <del>Jackson</del> Nehemiah 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip (1205 Raydale Court, Hyattsville, MD 20783 19a. Informant's Name/Relationship (Type, Print) John M. Wiser husband Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Glenwood Cemetery 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 03/24/05 Washington, DC 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bianchi 814 Upshur St NW Wash, DC 20011 23a. Part1. Enter tha disease shock, or heart failure. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between List only one cause on each line 2 DAYS Immediate Cause (Final Physician PROGRESSIVE SHOCK disease or condition resulting in death) /Medical Due to (or as a consequence of): 2 days Examiner MYOCARDIAL FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760. Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 🗓 No 4☐Pregnant at time of death 5 Other (specify) has been signed by the ge 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ACUTE RESPIRTORY DISTRESS, PRIOR STROKE, 23e. Did tobacco use contribute to the cause of death? þ RESPIRTORY 1 Yes 2 No 3 Probably 4 Unknown Completed POSSIBLE SEPSIS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2X No certificate ha 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٥ 1 ☐ Yes 2X No this After thi 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 X Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident Diractor: / 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 2 4 Homicide within 24 hours after To the Funeral Dirac Kertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier March 21, 2005 D36252 cause of death Item 23a) (Type, Print) AVE SUITES 30. Name and address Wheaton, Ho 20903

State

Registra

31. Date filed (Month, Day, Year)

MAR 2 4

GEDRAIA

11501

Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registras Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Year **Physician** 23:57 PM Stanley Clinton Almony, Sr. March 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Havre de Grace Harford Memorial Hospital Harford If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Day, ) 9/29/33 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 10XM 2□ F Director Yrs. 214-30-5320 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits itam 27 is marked othar than "netural", or Itams 23a or 28a-1 show othar traumatic evant, Itia Mcdical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director IVID Harford Perryman 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 422 Pollack Drive 21130 U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Myes 2 No If Yes, Give Year or Dates: Korean 1 ☐ Never Married 2 Married þ 1 ☐ Yes 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Laborer Carpenter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be fi and Mental H Leslie C. Almony Rose E. Grim 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a importent: if itam 27 is eny injury or other tra Wanda E. Almony (Spouse) 422 Pollack Drive, Perryman, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 MCremation 3 ☐ Removal from State A. Ferris & Co. 3/22/05 West Chester, PA \* 4 ☐ Donation 5 ☐ Other (Specify) Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or 3 a consequence of) obstructive pulmonary disease Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 □ No 3 □ Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes No ( Orllow Vyscu 2 No 1 Yes 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Certification: 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗀 Homicide 24 hours a 29a. Certifier 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal | Certifying Physician: 10 the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner. So stated.

2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) and 31. Date filed (Month, Day, Year) 32. Registrar's Signature MAR 2 4 2005 Registrar

			For State Registrar	State of M	laryland /		artment of H		l Mental Hyg	jiene () (	15	10054
	DI -:-:-		1. Decedent's Name (First, Middle,	Last)					Date of Dea     Month	Day	Y <i>e</i> ar	3. Time of Death
	Physicia /Medic		HOMER W.	AKRIDGE					MARCH		2005	15:55 M
	Examin		4a. Facility Name (If not institution,				4b. City, Town, o		path	4c. County		V
4		Ш	SHADY GROVE AD		ge (In yrs. last b	irthday)	ROCKVI		Irs. 8. Date of Birth		GOMEF	
	Funeral	2	5. Social Security Number 244-34-5590	5. Sex 7. Ad 1 <b>⊠</b> M 2 □ F	75	Yrs.	Months Days	Hours M	in. (Month, Day	, Year)	North	lace (State or Foreign try) 1 Carolina
	Director		Usual Residence of Decedent					1				
	yland	. [	10a. State 10b. County	- d d 1-	10c. City, To		cation Frederick				10	Od. Inside City Limits
	e Ma	ctol	Md. Fr	ederick			Tedericy	· 				1 ☐ Yes 2 🔀 No
	death with the Maryland ms 23a or 28a-f show	Oire	10e. Street and Number				10f. Zip Code	04.500		10g. Citizen of		
	ath w	ra	597 Cawley Dri		. 5:- II C	10	Was Basedon of L	21703			ed Sta	
	er de Items	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☑ Marrie	12. Was Decedent Armed Forces ad 1 ☑Yes 2 □	?	13.	If Yes, specify Cub	an, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	Bla	ck, White,	etc.
35	Irs aff	by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2 🗷 No	Specify:		Specif	y: Wh	nite
315-UU36	be filed within 72 hours after death with the Marylan Hygiene. d cither than "naturelt, or liems 23a or 28a-f show event, the Mcclical Examinating must be notified at	ted	15. Decedent's	s Education	16	a. Dece	dent's Usual Occup	ation	working	16b. Kind of B	usiness/Inc	dustry
	thin 7	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT use retire	d)				
7	filed within 7 Hygiene. other than "r ent, Ine Med	Co	12	2		]	Plumber	40 14-45-4-1	Inna (Fina Middle		nbing	
and and	be fill htal H even	Be	17. Father's Name (First, Middle, L Lonnie Lawr		dae			Ve1	Name <i>(First, Middl</i> e, .ma C <b>ru</b> m		110)	
<u> </u>	should by and Menta s marked umatic ev	ို	19a. Informant's Name/Relationsh			h Maili	na Address (Street		Rural Route Numbe		State. Zip	Code)
Maryland	d 2 sl th an th an traur		M. Jean Akridg						1A, Frede			21703
ō,	Health tem 27		20a. Method of Disposition		como	of Dispo	osition (Name of matory or other pla	cel	Date	20c. Location	- City or To	wn, State
ē	Pages net of I		1 ☐ Burial 2 🗷 Cremation 1 ☐ Donation 5 ☐ Other (Sp		9		litan Cre		3/07/05	Alexar	ndria,	, Va.
altimore,	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked any injury or other traumatic evance.		21. Signature of Funeral Service L	-	1		Name and Addre	es of Facility	er Funeral	Home		
ä	P P P P P		Murrel	W- 13a	rker	-	P. O. Bo	$\times$ 5038,	Laytons	ville,	Md.	20882
			23a. Part1. Enter the disease, or o shock, or heart failure. List of	complications that cause only one cause on each	ed the death. De line.	o not en	ter the mode of dyi	ng, such as care	diac or respiratory ar	rest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	Nov	100	سر	3-6	OLIN	cardia	Inta-	clien	2 LIKY.
П	/Medical Examiner		resulting in death)		s a consequenc	e of):		-		-		
		-	Sequentially list conditions,	b. Due to (or a	s a consequenc	(lo e:	197	vial	-Jibril	10 Flor	w ,	
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	000	1. 60		e i di v	0100	J 40	ilux	~	
<b>,</b>	execun n and ial-tra	Exai	that initiated events resulting in death) Last		is a consequenc	e of):	4	7	7 9	<u> </u>		
760	death certificate be executed e attending physician and id for use as the burial-transit	cai	,	(d. 1) K	15-1	No	NIA					
89	rtifical ng phy as th		IF FEMALE:					-				
Вох	leath certific attending p	an/Med	23b. Was decedent pregnant in the past 12 months?		2 Fetal dea		⊒Ectopic pregnand	y			ate of delive	ery Day Year
0.		Physicia	1 Yes 2 No	4□Pregnant 9□Unknown	at time of death	5 (	Other (specify) _					,
σ.	The law requires that the ste has been signed by th bage 2 should be detache	Ph)	Part II. Other significant conditio	ns contributing to death	but not resulting	g in the u	underlying cause gr	ven in Part I.	23e. Did to	obacco use cor	tribute to th	he cause of death?
Records,	uires that signed b d be det	d by	Chrent	C, (20	upha	DIC	1	cemy	יםו ים	(es 25 No	3 🗌 Prob	oably 4 Unknown
200	w require been sig should b	Completed	1170	nest en	21,00				24a. Was	an 24b.	Were auto	ppsy findings available impletion of cause of
Re	he lav e has	dmo	1 0	-1 1-	m-	,111	tur			rmed?	prior to condeath?	
Vital		a	25. Was case referred to medical	(2,261)	11.0	_ / / /		26. Place of	1 ☐ Yes  Death (Check only of		103	2010
	ysici is cer direct	OB	examiner?	Hospital: 1 Dupa	tient 2 ER/	Outpatie	nt 3 DOA	her: 4 🗌 Nursir	ng Home 5 🗌 Resid	dence 6 🗆 Ot	her (Specif	٤)
0	ding Phys h. After this funeral di	n: T	27. Manner of Death	28a. Dat of in	njury 28t	. Time o	of 28c. Inju	ry at	28d. Describe	now injury occu	rred	
<u> </u>	endir eath. or: Af	atic	2 Accident investig	ation				]Yes 2□No	Gart			
Division of	the Hospital or Attending Physicien: in 24 hours after death. the Funeral Director: After this certifical inpletely filled in by the funeral director.	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	inod 289. Place of I	Injury - At home, etc. (Specify)	farm, si	treet, factory, office		City or Tox		per or Hura	al Route Number,
	pital ours a seel Dilled i		29a. Certifier 1 Certifyin	g Physician: To the be	at of my knowles	too doa	th occurred at the t	ime, date and n	lace, and due to the	cause(s) and m	nanner as s	stated
	o the Hospital or ithin 24 hours afte to the Funerel Dir ompletely filled in	edical	(Check only 2 Medical I	Examiner: On the basis and manner	of examination stated.	and/or i	nvestigation, in my	opinion, death o	occurred at the time,	date and place	, and due to	o the cause(s)
	To the Hospital or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	Me	29b. Signature and title of certifier				29c. Licen	se number		29d. Date sign	ed (Month,	Day, Year)
			Minus	3411			D	21116	7 8UD	200	, wh	, E 2005
24	5 +1	1	30. Name and address of person	who completed cause o	I death (Item 23	a) (Type	, Print)				- Cv	0 20876
			1. Ganti	10,29	d De	30	Cars ),	1116	GEIM	dufa	ru, "	Day, Year)  C 2 005
	Sta		31. Date liled (Month, Day, Year)	2005 32 Regis	strar's Signature	A	arte					
	Regist	ar	G O MAINI	LUUJ	MAN JU	101	1					

			For State Registrar	State of Ma	aryland		artment of tificate o			Reg. No.	5 10	055
	Physici	an	Decedent's Name (First, Middle,     VIRGINIA MY		Н				2. Date of D Month MARCH	Day	Year	ne of Death : 31 P <sup>M</sup>
	/Medio Examin		4a. Facility Name (If not institution,	give street and number)	-	m 3 T	4b. City, Town			4c. County	of Death	
			FREDERICK M			'I'AL ast birthday)	FREDE	ır If Under	24 Hrs. 8. Date of B		ERICK  9. Birthplace (S	tate or Foreign
-	Funeral Director		213-78-7066	1□M 2 <b>□</b> F	80	Yrs.	Months Day	s Hours	NOV 2	1924	9. Birthplace (S Country) MD	)
	yland now		Usual Residence of Decedent  10a. State 10b. County			, Town or Lo						de City Limits
	8a-fst	ector	MD FREDE	RICK	BR	UNSWI				10g. Citizen of \		Yes 2□No
	h with ti	ai Dir	10e. Street and Number 620 6th AVE.,	#206,			10f. Zip Code 217				SA	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itema 23a or 28a-f show any follury or other traumatic event, the Marilial Exatr. Art must be notified at once.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Marrie 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces?  If Yes, Give Year or Dates:	,	1	Was Decedent of Yes, specify C		igin? (Specify Yes or N n, Puerto Rican, etc.)	o- 14. Rad Blad Specify	e - American Indi ck, White, etc.	
21215-0036	within 72 hou ene. than "natura he wedigal E	Completed	15. Decedent' (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4or 5	5+)	(Give life.	dent's Usual Occ kind of work doi DO NOT use ret SEWIFE	ne during mos	st of working	16b. Kind of B	usiness/Industry	
Maryland 2	uld be filed Aental Hygi rked other tilc event, I	To Be Co	17. Father's Name (First, Middle, L RAY DAVIS	ast)					er's Name <i>(First, Middl</i> PFIE McDOI		ne)	
Mary	d 2 sho th and h t7 ls ma trauma		19a. Informant's Name/Relationsh VERONICA GRIM		ER				er or Rural Route Num , MARTIN:			1
ore,	es 1 an of Heal f Item 2 r other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □Removal from State	CE	emetery, crei	sition (Name of matory or other p		Date		City or Town, Sta	
Baltimore,	it. Pag rtment rtant: I njury o		'4 □Donation 5 □Other (Sp 21. Signature - un val S vice	ecify)	MON		CEMET  Name and Ade		3/24/05	BEALLS	VILLE,	MD
Ba	Depa Impo any is		Me. 4	M		I F	IILTON P.O. BO	FUNER	AL HOME BARNESV	ILLE, M	D 2083	88
	Physician /Medical		23a. Part1. Enter the disease, or shock, or heart failure. List of immediate Cause (Final disease or condition resulting in death)	a	151S		er the mode of o	lying, such as	cardiac or respiratory	arrest,	Onset	ximate al Between and Death
ì	Examiner			Due to (or as	a consequ	vence of):	al fa	ilur	e		d	days
£/-	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Auc Due to (or as	a consequ	ience of):	waten	n fa	ilme		0	lays
760, =	ate be executed hysician and he burial-transit	cal Exar	that initiated events resulting in death) Last	c. Due to (or as	a consequ	uence of):		<i>J</i>				
99	ertificat ding phy se as th		IF FEMALE:	23c. If yes, outcome	of pregna	nev				02d D	to of delivery	
.O. Box	es that the death certifica Igned by the attending ph be detached for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ Vo 9 ☐ Unknown	1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3[	□Ectopic pregna □ Other ( <i>specify</i> )				ite of delivery onth Day	Year
rds, P	The taw requires that the te has been signed by thoage 2 should be detache	þ	Part II. Other significant condition  Diahere	ns contributing to death by Mullas		ulting in the u	nderlying cause	given in Part		tobacco use con	tribute to the caus	
Vital Record	10 12	Completed	chronic pu	lifferen Os	Cal	itus	e Di80	are		opsy formed?	Were autopsy fini prior to completio death? 1 \( \text{Yes} \) 2 \( \text{N} \)	n of cause of
Vita	Physician: The this certificate ral director, pag	To Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:	ent 2	EB/Outnatie	nt 3□ DOA		e of Death <i>(Check onl</i> ) ursing Home 5 🗆 Re		ner (Specify)	
Division of	ding h. After fune		27. Manner of Death  Natural 5 Pending investig	28a. te of Inju (Month, Da	ury	28b. Time o Injury	f 28c. Ir	njury at Vork?	28d. Describ	e how injury occur		
Divis	T the	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 286. Place of in	jury - At ho tc. (Specify	ome, farm, st	reet, factory, offi	СӨ		(Street and Num own, State)	ber or Rural Route	Number,
	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	edical C	29a. Certifier (Check only one)  Certifyin 2 Medical I	g Physician: To the best examiner: On the basis of and manner st	of examinat	wledge, deat tion and/or in	h occurred at the vestigation, in m	time, date a y opinion, de	nd place, and due to the ath occurred at the time	e cause(s) and m e, date and place,	anner as stated. and due to the ca	use(s)
	To the To the COMP	Me	29b. Signature and title of certifier					ense number	G.		ed (Month, Day, Y	
)	ĺ		30. Name and address of person	who completed cause of	death (Item	1 23a) (Tvne	Print) C	4/16 HANI	9 -HING F	10 . na.v	2	1
	- 1		610 am	tve., Br	uns	will		221		7.0.71	3	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) MAR 2 4		rar's Signa	ture	arte					

DHMH 17 Rev 1/2001

			1 _ State	tate of Maryland /	Department Certificate			711115	10056
			Registrar  1. Decedent's Name (First, Middle, Last)		Certificate	Ol Death	Reg. I	No: O O O	3. Time of Death
	Physic		MARY JO BARK	E D			Month	Day Year	
	/Medi Examir		4a. Facility Name (If not institution, give street		4b. City, To	own, or Location of Death		4c. County of Death	7:20 P <sup>™</sup>
	xa,iiii	i.c.	CHARLES COUNTY N	URSING & REE	IAB L	A PLATA		CHAR	RLES
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last b	irthday) If Under 1		8. Date of Birth (Month, Day, Yes		place (State or Foreign ntry)
	Director		233-44-3527	2X) F 75	Yrs.	34,7			. V .
	and		Usual Residence of Decedent  10a. State 10b. County	10c. City, Tox	vn or Location			1	10d. Inside City Limits
	Marylan f ahow	ō	MARYLAND CHARL	E.C.	TA DIAM	7			1 XYes 2 No
	the 28a	rec	10e. Street and Number	L3	LA PLATA		10g.	Citizen of What Cour	ntry?
	3a or	Funeral Director	10200 LA PLATA RO	OAD		20646		U.S.A.	
	ter deat	ner	11. Marital Status 12.	Was Decedent Ever in U.S. Armed Forces?	13. Was Deceder	nt of Hispanic Origin? (Spe y Cuban, Mexican, Puerto F	cify Yes or No-	14. Race - Americ	can Indian,
9	or Ite	/Fu	1 Never Married 2 Married	1 Yes 2 No	1 ☐ Yes 25		iican, etc.)	Black, White,	etc.
8	ural',	d by	3 \( \Divorced \)	Year or Dates:				WF	HITE
21215-0036	ba filed within 72 hours after death with the Maryland tal Hyglene. Id other than "natural", or Items 23a or 28a-1 ahow event, the Medical Evariller is unative neith, or	Completed	15. Decedent's Education (Specify only highest grade co	on 16a ompleted)	(Give kind of work	Occupation done during most of workin retired)	g 16b.	. Kind of Business/In	dustry
12	withir ene. then	mc	Elementary/Secondary (0-12)	College (1-4or 5+)				OGDIMAL	~
	filed with Hygiene. other thar		17. Father's Name (First, Middle, Last)	3   K	EGISTER	ED NURSE 18. Mother's Name		OSPITALS en Sumame)	<u>i</u>
Maryland		To Be	VIRGIL ODELL CA	ASTO		AUDREY	GENTVT	EVE SKID	MORE
ary	o,	-	19a. Informant's Name/Relationship (Type,	Print) 19	b. Mailing Address (S	Street and Number or Rural			
	ē = N ⊾		KENNETH BARKER-SO	ON 1	5660 CLC	OVERLEAF CT	HUGHE	SVILLE, M	ID 20637
ore,	~ I & E		20a. Method of Disposition	20b. Place	of Disposition (Name	of Da		Location - City or To	
Baltimore,	Pages nent of I ant: If its ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Remo `4 ☐ Donation 5 ☐ Other (Specify) ☐		YLER MTN	.MEM.GDNS	3-23-05	TYLER M	OHNTATNIN
att	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensee	M00479	22. Name and	Address of Facility			20112:12:07
<u> </u>	2012		Mucha &	Sun	TA PLA	D FUNERAL	SERVICE ND. 2064		
П			23a. Part1. Enter the disease, or complicati shock, or heart failure. List only one c	one that caused the death. Do ause on each line.		1		10	Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	Congesting	Heari	+ failur	u		Onset and Death
	/Medical Examiner		resulting in death)	Due to (d as a consequence	of):				
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F	isi 🧖	Examiner	cause. Enter Underlying Cause (Disease or injury	Oue to (or as a consequence	or):				
The same	be executed ician and burial-transit	xan	that initiated events c resulting in death) Last	Due to (or as a consequence	of);	<del></del>			
8760,	sate be executed by sician and the burial-transit	icai E							
687	law requires that the death certificate as been signed by the attending phys 2 should be detached for use as the	edic	a						
Вох	eath certific attending p	M		If yes, outcome of pregnancy	_			23d. Date of delive	erv
	death e atte d for	icia	in the past 12 months?	1 Live birth 2 Fetal death 4 Pregnant at time of death	n 3 □Ectopic preg 5 □ Other (spec			Month	Day Year
P.0	at the de by the a tached	Physician/Med	9 Unknown	9 Unknown					
	res that signed to be det	by P	Part II. Other significant conditions contrib	uting to death but not resulting	in the underlying cau	se given in Part I.	23e. Did tobacc	o use contribute to th	ne cause of death?
ıd	w require been sig should b						1 ☐ Yes	270 No 3□ Prob	pably 4 Unknown
Vital Records,	e law re has bei je 2 sho	Completed					24a. Was an autopsy	24b. Were auto	psy findings available
Ä	The ate h page	E O					performed?	death?	mpletion of cause of
ita	ysician: Th is certificate director, pag	Be C	25. Was case referred to medical examiner?			26. Place of Death			
of V	G is	2	1 ☐ Yes 2 No	1 Unpatient 2 LEH/O	utpatient 3 DOA	Other: 4 Nursing Hom	e 5 🗆 Residence	6 ☐Other (Specify	y)
υ,	ng Ph fter th ineral	on:	27. Manner of Death 2  ↑ Annual 5 ☐ Pending		Time of 28c	: Injury at 2: Work?	3d. Describe how in	jury occurred	
Sio	Attending or death. ector: After by the funer	cati	2 Accident investigation		М	1 ☐ Yes 2 ☐ No			
Division		Certification;	4 Homicide determined 2	<ol> <li>Place of Injury - At home, f. building, etc. (Specify)</li> </ol>	arm, street, factory, o	office 2	31. Location (Street City or Town, Sta	a <i>nd Number</i> o <i>r Rur</i> a ite)	I Route Number,
	To the Hospital or within 24 hours after To the Funeral Director completely filled in		COL CONTROL AND CONTROL OF THE COLUMN						
	To the Hospital within 24 hours a To the Funeral completely filled	edicai	29a. Certifier  (Check only one)  1 Certifying Physicia 2 Medical Exeminer:	an: To the best of my knowledg On the basis of examination as and manner stated.	e, death occurred at nd/or investigation, in	the time, date and place, ar my opinion, death occurre	id due to the cause d at the time, date a	(s) and manner as st ind place, and due to	ated. the cause(s)
	To the within 2 To the complet	Med			29c. L	icense number	29d. [	Date signed (Month, I	Dav. Year)
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•	3		30. Name and address of person who compl	leted cause of death (Item 23a)	(Type, Print)			1 /	
			NALIN MATHUR, M	D. 105	t. PATRICI	ks Da. Su	te 301/	Wal., 1	nd.
\$7	s Sta	te	31. Date filed (Month Day Year)	62. Registrar's Signature	1.4.				30003
	Registi	ar	29b. Signature and title of certifier  A Com May  30. Name and address of person who completed in the complete of the complete	Bloom 15 1	Core				

	-	State of Marylan  State of Marylan  Registrar		artment of H tificate of L			giene 0	05	10057
Physicia		1. Decedent's Name (First, Middle, Last)				2. Date of Dea	ath Day	Year	3. Time of Death
/Medica	al -	EDWARD VINCENT BEVAN		Ab City Town or	Location of Death	03	18 Count	y of Death	12:49 p.m.
Examine	r	sa. Facility Name (If not institution, give street and number)		Ab. City, Town, or	20 and		$\Delta \Pi$	2GA1	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	h v. Year)	9. Birthp	ac (State or Foreign
Director	-	216 30 1929 1 1 2 7 7 3 Usual Residence of Decedent	Yrs.			FEB 17	1932	MAR	ŽLAND
yland	-		y, Town or Lo	cation				1	Od. Inside City Limits
r 28a-f show	cto	MARYLAND ALLEGANY FR	OSTBUR	G					1 ŽYes 2 □ No
with th	Director	10e. Street and Number		10f. Zip Code	2.2		10g. Citizen of	What Coun	try?
ms 23	Funeral	240 WELSH HILL           11. Marital Status         12. Was Decedent Ever in U	.S. 13. V	215 Was Decedent of H	ispanic Origin? (Sp. n, Mexican, Puerto	ecify Yes or No		ce - Americ	
1036  ours after death with ral', or Items 23a or Examinat must be		1 Never Married 2 Married 1 Yes 2 No	İ	fYes, specify Cuba I⊡ Yes 2 <b>⊡X</b> No	n, Mexican, Puerto Specify:	Rican, etc.)	Speci	ack, White, o	
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215-0 Ithin 72 ho ien "netur	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0·12) College (1·4or 5+)	(Give	lent's Usual Occupa kind of work done o DO NOT use retired	turina most of work	ing	16b. Kind of E	ousiness/inc	lustry
N 200 2	E	12	POL	ICE CHIEF					DEPARTMENT
be filed had had had hyging of other event, in	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name				
Paga Z ≥	ို	EDWARD BEVAN  19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	a Address (Street a	LOTTIE (				Code)
C = 14 F		STEPHEN BEVAN / SON			ILL ROAD,				
O		20a. Method of Disposition 1 ☐ Burial 2 (A) Cremation 3 ☐ Removal from State	lace of Dispo	sition (Name of natory or other plac	ا (	Date	20c. Location		
Limor Pages Iment of tant: If it		`4 □ Donation 5 □ Other (Specify) TH		ERLAND CR	EMATORI	19/05	CUMBERI		
Baltimed permit. Pag Department Important: I any injury o once.		21. Signature of Funeral Service Licensee  Moo. Moo. Moo.		Name and Addres	ss of Facility ERAL HOME	E. P.A.	60 W. FROSTI		STREET MD 21532
	-	23a. Pag1. Enter the disease, or complications that caused the deat						borto,	Approximate Interval Between
Pnysician		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition	0 500	ENO TIC.	VASCU	on D	15EAS	E	Onset and Death
/Medical Examiner		resulting in death)  Due to (or as a consequence)		J-V ).C					70 -1.3
1000	_	Sequentially list conditions, b	uende of						
A uted	Examiner	Sequentially list conditions, if any, isading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.							
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Geath cert eath cert eath cert do for use	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No		Ectopic pregnancy Other (specify)					Day Year
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S, es ti igne be c	2	Part II. Other significant conditions contributing to death but not res	ulting in the ur	nderlying cause give	en in Part I,		obacco use con ⁄es 2 □ No	itribute to th	e cause of death?
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	BeC	25. Was case referred to medical, examiner?			26. Place of Deat	1 ☐ Yes h (Check only o	2X No	1 1 1 1 1 1 1 1 1 1	20 100
hye this all dii	P.	T⊠Yes 2 No Hospital. 1 Inpatient 2 No	ER/Outpatien	t 3 DOA Othe	9r: 4 ☐ Nursing Ho				)
Division of to attending Phy after death. Director: After this lin by the funeral d	Certification:	27. Manner of Death  1	28b. Time of Injury	Worl	/ at k? Yes 2 □ No	28d. Describe h	now injury occu	rred	
Divisio  I or Attandi after death. Diractor: A	flca	3 Suicide 6 Could not be determined 28e. Place of Injury - At he				28f. Location (S		ber or Rura	Route Number,
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o the vithin 2 o that o that o omple	Med	29b. Signature and title of certifier		29c. License			29d. Date signe	ed (Month, I	Day, Year)
FSFO		· augeen logue	MO.	D-	-0013160	0	03-	18	2005
10		30. Name and address of person who completed cause of death (Iter	n 23a) (Type	Print)	1/1 -	ne A	0 -	222	
(¢		31. Date filed (Month, Day, Year)  22. Registrar's Signa	ture		5 me	my all	X Y	V 2 1	
Stat Registra		MAR 2 4 2005	Some	E)					
			-	4.5					

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 5 Day **Physician** MARCH 2005 THADDEUS BUSSARD 8:30 PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner MONTGOMERY GENERAL HOSPITAL OLNEY MONTGOMERY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day Year) Dec. 10 1922 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1**⊠**M 2□ F 212-24-4988 82 Yrs. Director Maryland Usual Residence of Decedent the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "naturel; or items 23e or 28a-f show any jury or other traumatic event, the Medical Examble Training the profiling an once. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. Montgomery Derwood 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18204 Muncaster Road 20855 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ★No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 □ Never Married 2 ▼ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White þ Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 11 Farmer Farming 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Harry Tyson Bussard Katherine Lawson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mildred G. Bussard / Wife 18204 Muncaster Road, Derwood, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🛣 Burial 2 □ Cremation 3 □ Removal from State Holy Rosary Cemetery 3/10/05 \* 4 ☐ Donation 5 ☐ Other (Specify) Dundalk, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Muriel H. Barber Funeral Home Box 5038, Laytonsville, Md. P. O. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS Physician 2 DAYS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner certificate be executed the burial-transit resulting in death) Last Due to (or as a consequence of): the attending physician Box 68760 Physician/Medical use as t IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) P.0. ☐Yes 2☐No 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown DEMENTIA Completed peen 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Tyes Hospital or Attending Physicien: director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 ☐ Yes 2 No 12 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Injury 1 Natural 5 Pending 1 □ Yes 2 □ No after death. investigation Accident Accident Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a e Funeral I 29a. Certifier 🖒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To tha P within 24 To the F 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) M. Hann MARCH 6, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2901 DLNEY-SANDY SPRING ROAD, DLNEY, MARYLAND DENNIS HANNON, MD 31. Date filed (Month, Day, Year) MAR 0 9 2005 Registrar

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	Physici	an	Decedent's Name (First, Middle,	Last)						<ol><li>Date of Deal Month</li></ol>		Year	3. Time of Death
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	Examin	er	4a. Facility Name (If not institution,	give street and number	)	4b. City,	Town, o	r Location of	of Death		4c. County of	of Death	
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	Funeral Director		5. Social Security Number	5. Sex 7. A	ge (In yrs. last birth	Months	Days	Hours	Min.	8. Date of Birth (Month, Day, <b>July</b> 30	Year) 1945	9. Births	place (State or Foreign htry) <b>iti</b>
			356 38 3369 Usual Residence of Decedent				L	L		oury so	, 1743	Па	TLI
	yłanc now		10a. State 10b. County		10c. City, Town	or Location						1	0d. Inside City Limits
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	r dea	nei	11. Marital Status	12. Was Deceden Armed Forces	?	13. Was Dece If Yes, spe	dent of H	lispanic Ori an, Mexican	gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)	14. Race		can Indian, etc.
36	or II	ΥĒ	1 Never Married 2 Married	If Yes, Give		1 🗆 Yes	No.	Specify:			Specify:		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any iluryporther traumatic event, the Modreal Extended to 100	d b	3 Widowed 4 Divorced	Year or Dates:		Sana da ada 11a.	-10						
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Vithi To t	Σ	29b. Signature and title of certifier	1/2011		29c. Licens	se number	2	9d. Date signed (	Month, Day, Year)
(1		30. Name and address of person who co	HOLL	23a) /Tues	DY7	621		3-9.0	7
(3)		Kathleen M. Hoe	/			. Centres	ville.Mar	vland 91	617
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ORIGINAL

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien 1 - For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Year **Physician** March 12, 2005 4:05 a.m. Ella May Brewer /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner St. Mary's Nursing Center Mary's Leonardtown If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min. 1 M 2000 **Director** 214-12-9349 1913 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28e-f show other treumatic event, the Madical Examiner must be multiled at 1 Yes 2/0/No Director St. Mary's Maryland | Hollywood 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ or Items 23e 43555 John B. Thompson Road Funeral 20636 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 1 Never Married 2 Married □Yes 2 XNo Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates: Specify: White Completed by 3 X Widowed 4 □ Divorced "netural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill treent of Health and Mental Hitem 27 Is marked others. Be Harry Hayes Joy Alice May Dean 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Erma J. Thompson / Niece 43555 John B. Thompson Road, Hollywood, MD 20636 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State injury or permit. Page Department of Importent: If eny injury or once. 4 Donation 5 Other (Specify) Church of the Nazarene 3-15-2005 Hollywood, Maryland 21. Signature of tuneral pervice profise Edward N. Brinsfield, Jr. 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD M00052 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cardio respiratory arrest /Medical Due to (or as a consequence of): **Examiner** Failure to thrive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Bi olar dis burial-trar Due to (or as a consequence of) Box 68760, attending physician Physiclan/Medical H oth roidism IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🔯 No Month Year Day 4 Pregnant at time of death 5 Other (specify) ed by the detached Division of Vital Records, P.O. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ed bluods 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a Wasan has autopsy 2X No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital: ٩ 1 🗌 Yes 2**X** No 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After or Attending 5 Pending investigation 1 X Natural Injury death. 1 Yes 2 No 2 Accident Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by determined 4 Thomicide within 24 hours a To the Funerel L 1 X Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number a D47066 March 14, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Avani D. Shah, M.D., 22650 Cedar Lane Court, Leonardtown, MD 20650 31. Date filed (Month, Day, Year) 32. Signature State MAR 1 6 2005 Registrar

			Registrar			Oen	illicate of	Dealii		Reg. No.			
	Physic	ian	Decedent's Name (First, Middle, La						2. Date of E	Day	Year		of Death
	/Medi		4a. Facility Name (If not institution, gir	n Joseph E			4b. City, Town, o	r Location of D	MARCH		2005 unty of Deat	9:14	a <sup>M</sup>
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	Funeral		St. Mary's Hosp 5. Social Security Number 6.		ge (In yrs. last bi	rthday)	Leonard If Under 1 Year	If Under 24 I		Birth	nt Ma:	hplace (State	or Foreigr
	Director		220-16-4426 Usual Residence of Decedent	1፟⊠M 2□F	86	Yrs.	Months Days	Hours N	Min. (Month, L March 1	Day, Year) 5, 1919		o <i>untry)</i> nsylvani	.a
	ryland		10a. State 10b. County		10c. City, Tow	m or Loc	ation			***************************************		10d. Inside	-
	the Ma	Director	Maryland Saint Ma	ary's	Abel1		10f. Zip Code			10g. Citizen	of Min at Co		es 2√∏No
	h with	al Dir	20827 Abell Road				20606			USA	or what Co	untry?	
	deati	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. W		lispanic Origin?	? (Specify Yes or Nuerto Rican, etc.)			ncan Indian,	
920	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene, itam 27 is marked other than "natural", or flams 23e or 28e-f show other traumatic avent, the Medical Eventher must be notified at	by Funeral	1 ☐ Never Married 2 页 Married 3 ☐ Widowed 4 ☐ Divorced	1 ∑ Yes 2 ☐ If Yes, Give Year or Dates:	No	1	☐ Yes 2🛱 No		derio modri, etc.)	1	Black, White ec <i>ify:</i> B1a		
2-0	72 ho	eted	15. Decedent's E (Specify only highest gr	ducation	16a	. Decede	ent's Usual Occup	ation	working	16b. Kind o	f Business/	Industry	
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b	illed Hyg other	BeC	17. Father's Name (First, Middle, Las	1)		Баос	,101	18. Mother's	Name (First, Midd			·	
<u>a</u>	ald be fenta rked tic av	To B	John Branson					Marga	ret Collin	s			
Maryland	should and A		19a. Informant's Name/Relationship	(Type, Print)	191	. Mailing	Address (Street	and Number or	r Rural Route Num	ber, City or To	wn, State, Z	žip Code)	
	and 2 ealth n 27 I		Elnora Virginia Bran	son / Wife	20	827	Abell Road	, Abell,	Maryland 2	20606			
ore	of He of He if itan		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 [	Removal from State	comoto	f Dispos	ition (Name of atory or other plac	(8)	Date March	20c. Location	on - City or	Town, State	
Ē	Pages ment of t ant: If its		* 4 ☐ Donation 5 ☐ Other (Speci	fy)		Hear	t Cemetery	21,	, 2005	Bushwoo	d, Mar	y1and	
Baltimore,	permit. Pages 1 and 2 s Department of Health an Important: If itam 27 Is any injury or other trau <u>once</u> .		21. Signatur of Funeral Service Lice	nsee		22. Mat	Name and Addre	ss of Facility ard <b>i</b> ner F	uneral Hom	e, P.A.			
	00500		michael Nur	n Harden	u >				town, Mary		50		
			23a. Part1. Enter the disease, or conshock, or heart failure. List only	one oddago on oddin	110.				diac or respiratory	arrest,		Approxim Interval B Onset and	atween
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)				Inforct	ion.					
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	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events										
o,	exec an an rial-tr		resulting in death) Last	Due to (or as	a consequence	of):							
Box 68760,	th certificate be executed tending physician and or use as the burial-transit	an/Medical	•	_ d									
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Bo)	ath coattend	ian/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death		Ectopic pregnancy			23d.	Date of deli Month	ivery Day	Year
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σ.	res that the death igned by the atter be detached for i	h h	Part II. Other significant conditions	contributing to death b	out not resulting i	n the un	derlying cause giv	en in Part I.	23e. Did	I tobacco use c	ontribute to	the cause of	death?
rds,	es De	d by							1 🗆	]Yes 2□No	3 🗆 Pro	obably 4	∄Unknown
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ital		a	25. Was case referred to medical					26. Place of I	Death (Check only	2 No	1 1 1 1 1 1 1 1	2 140	
f V	Physician: this certitics ral director, I	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1   Inpatio	ent 2 FR/OI	utpatient	3□ DOA Oth	er: 4 🗆 Nursin	g Home 5 ☐ Res	sidence 6 🗆	Other (Spec	city)	150
	iding Phy th. After thi funeral of		27. Manner of Death  1 ☑ Natural 5 ☐ Pending	28a. Date of Inju	iry 28b.	Time of	28c. Injur Wor	y at k?		how injury oc			
Sio	death. ctor: Al	atic	2 ☐ Accident investigation	n				Yes 2 □ No					
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	To the Hospital within 24 hours a To the Funaral I completely tilled	edical (	29a. Certifier 1 Certifying Pt (Check only one)	hysician: To the best miner: On the basis o and manner st	f examination ar	e, death	occurred at the tinestigation, in my o	ne, date and pl pinion, death o	ace, and due to the	e cause(s) and e, date and plac	manner as e, and due	stated. to the cause	(s)
	Fo the within Fo the complex c	₩ Me	29b. Signature and title of certifier	7/		-	29c. Licens	e number		29d. Date sig	ned (Month	n, Day, Year)	
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L	M		30. Name and address of person who	completed cause of	leath (Item 23a)	(Type, P		, , , ,		7. 11110			
- )	16		ANGELO FALCONE	ST. MARY	'S HOSP	ITAI	LEONA	RDTOWN	MD 2065	50			
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	Registr		MAR 17	2005	san K		nert -						
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			1 - For State Registrar	State of Marylai		artment of F			giene Reg. N2 0 0 5	10063
			Decedent's Name (First, Middle, Last,					2. Date of Dea	ith	3. Time of Death
	Physicia		Joan Ann Bea	lefeld				March	8 2005	໌ 7:05 ຍ м
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, c	r Location of Death	1	4c. County of De	ath
	Exami	Ϋ.	Dorchester Gene	ral Hospital		Caml	oridge		Dorc	hester
	Funeral		5. Social Security Number 6. Se			If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	9. B	irthplace (State or Foreign Country)
	Director		214-38-6532	M 2√F 64	Yrs.	Monato Bayo		Oct. 27		aryland
	p .		Usual Residence of Decedent  10a. State 10b. County	10c C	ity, Town or Lo	ocation				10d. Inside City Limits
	Maryland -f ehow fled at	ž	MD Dorches		ny, rown or E	Winga	ate			1 ☐ Yes 2 No
7	Pe M	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What (	
7	with the	늄	2137 Farm Creek	Poad		TOI. Zip Code	21675		USA	South y :
7	within 72 hours after death with the Marylan han ". A Marilcul Eran i er nam be notified at A Marilcul Eran i er nam be notified at	Funeral	11, Marital Status	12. Was Decedent Ever in U	IS 13	Was Decedent of h		pecify Yes or No-		nerican Indian,
7	iterr iterr	'n	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 No		Was Decedent of H If Yes, specify Cub	an, Mexican, Puert	o Rican, etc.)	Black, Wi	nite, etc.
25	hours after turel', or ite	by I	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:		Specify: \	white
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Maryland		٥	Louis A. Reed	<u> </u>			Oliv	e Ridgew	ay	
a L	d 2 should th and Mer 7 is marke treumatic		19a. Informant's Name/Relationship (T)						r, City or Town, State	, Zip Code)
	C = 0 -		John Bealefeld	husband		Farm Cre				
ore	ite.		20a. Method of Disposition 1 Burial 2 Cremation 3 6	Removal from State	Place of Dispo cemetery, cre	osition (Name of matory or other pla	ce)	Date	20c. Location - City	or Town, State
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<u>a</u>	permit. Departi Importi any inj		21. Signature of Funeral Service Licens	99	2	2. Name and Addre	ess of Facility Th	omas Fun	eral Home	P.A.
<u> </u>	20599		John () Sor			00 Locust				
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	/Medical		resulting in death)	Due to (or as a conse	quence of):					
	Examiner		Sequentially list conditions.	b						
	p ti	inei	Sequentially list conditions, if any, leading to immediate cause. Enter Under in Causa (Disease or injury	Due to (or as a conse	quence of):					
	and and trans	Examiner	that initiated events resulting in death) Last	c	quança of):					<del> </del>
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2	that fi		Part II. Other significant conditions co	ntributing to death but not re	sulting in the u	underlying cause gr	ven in Part I.	23e. Did to	bacco use contribute	to the cause of death?
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o	ding F. h. After funer	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury		rk? ]Yes 2 □No			
Division	or Attending Physicien: ufer death. Director: After this certific in by the funeral director,	ertification:	3 Suicide 6 Could not be	28e. Place of Injury - At		reet, factory, office		28f. Location (S	Street and Number or	Rural Route Number,
2		erti	4  Homicide	building, etc. (Spec	eify)			City or Tow	m, State)	
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	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical	(Check only 2 Medical Exam	iner: On the basis of examir and manner stated.	nation and/or in	nvestigation, in my	opinion, death occu	urred at the time, o	date and place, and d	ue to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier		Z.	29c. Licen	se number		29d. Date signed (Mo	onth, Day, Year)
				No cu	20	D2	C040		3/8/09	S
			30. Name and address of person who o	mplete cause of death (Ite	em 23a) (Type	Print)		4 00	->	D 21613
			CRAZES 5. SCH	Acter my	,100	BRARIES	ES (,	CARMBIZ	204E, W	D 21610
	Sta		31. Date filed (Months Gar Year) 1 2	32. Begistrar's Sign	nature	les de s				
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 1a/ch 0 /Medical 4ax Fecility Name (If not institution, gife street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner OMIC iat Security Number If Under 1 Year 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Hours 1**⊠**M 2□ F Deys Yrs 220-26-3934 79 June 4, Director 1925 Northern Ireland Usual Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or items 23a or 28a-f show eny injury or other treumatic event, the Medical Examinat must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Dorchester 1 XYes 2 □ No Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 309 Oakley St. 21613 USA Funerai 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 X Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0020 1 ☐ Yes 2 🗷 No Specify: ģ Year or Dates: WWII Specify: white 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 salesman insurance 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) Be Victor Burns ပ Elizabeth Rankin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Shirley Hastings 309 Oakley St., Cambridge, MD p.r. 21613 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dorchester Memorial Park 3/14/05 Cambridge, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 21613 But )illum 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate tnterval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner To the Hospital or Attanding Physicien: The law requires that the death certificate be executed within 24 hours either death.

To the Zunerel Director: Atten this certificate has been signed by the ettending physician end completely filled in by the funeral director, page 2 should be detached for use as the bunel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobecco use contribute to the ceuse of deeth? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown þ 24a. Was an autopsy performed? 24b. Were eutopsy findings eveilable prior to completion of cause of death? Completed 2 No 1 🗆 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ို 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) Medical Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MDUN 39. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature State Registrar

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene | 15 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 10 Day 2005 Pear **Physician** Charles H. Brown, Jr. 12:15 am /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Mallard Bay Care Center Cambridge Dorchester If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day Yes Jan. 26, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Mary Land **Funeral** 12M 2□F Months Days Hours 75 Yrs. 213-30-8450 Director Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits itam 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Exerther must be notified at Caroline 1 Des 2 No Maryland Denton Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 420 Colonial Drive 21629 Completed by Funeral death y 11. Marital Status unknown 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 | Yes 2 | No If Yes, Give Year or Dates: unknown Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other than any injury or other traumatic avant the asset Elementary/Secondary (0-12) College (1-4or 5+) unknown unknown unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles H. Brown, Sr. Beatrice Pence 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carl E. Burke/Guardian 100 Schauber Rd., Chestertown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State MidShoreCremationCenter 3/11/2005 Cambridge, Maryland ¹ 4 □ Donation 5 □ Other (Specify) 21. Signa e of Fu eral Service Licensee 22. Name and Address of Facility Moore Funeral Home, P.A. 12 South Second St., Der Denton, MD 21629 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Proysician stage renal end /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, hand, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner burial-transit pertension Due to (of as a consequence of): Box 68760, attending physicien The law requires that the death certificate be Physician/Medical as the IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. the detached 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 22 No 3 ☐ Probably 4 ☐Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1 ☐ Yes Hospital or Attanding Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 2 this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Certification: 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident **Diractor**: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To tha 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) HO0599 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 17 100 Bramble St., Cambridge, MD 21613 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar MAR 1 4 2005

,			State of Maryland / Department of Health and  1- State Registrar  Certificate of Death		iene	5 10066
	Physici	an	Decedent's Name (First, Middle, Last)	2. Date of Dea Month MARCH	th _	3. Time of Death
	/Media	al	GERARD PERSHING CALHOUN  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Dec		15 200	
	Examin	er	FROSTBURG VILLAGE NURSING HOME FROSTBURG	iau i	ALLEGA	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hr Months Days Hours Mir		Year) 9.	Birthplace (State or Foreign Country)
	Director		236 03 8810 87 Yrs. Usual Residence of Decedent	JULY 27	1917 W	EST VIRGINIA
	ryland how		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Ba-f s	ecto	MARYLAND ALLEGANY FROSTBURG			1. Yes 2 □ No
	with t	Dir	10e. Street and Number 10f. Zip Code 228 BRADDOCK STREET, APT. 211 21532	1	0g. Citizen of What	: Country?
	death	nera		(Specify Yes or No-	14. Race - A	merican Indian,
36	72 hours after death with the Maryland naturel', or Hems 23e or 28e-f show Jisal Examination invalve invilled at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces? WW J. If Yes, specify Cuban, Mexican, Pue If Yes, Give KOREAN Year or Dates:  13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue If Yes, Give KOREAN 1 Yes 2 No Specify:	erto nican, etc.)	Specific	/hite, etc.
21215-0036	hours turel	ed b	3 Widowed 4 Divorced Year or Dates:  15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of Busine	WHITE
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7	led wil lygien her th	Con	+8 TEACHER / COACH		PUBLIC S	CHOOL
Maryland	d be fi	o Be		lame <i>(First, Middl</i> e, <i>I</i> PHIA (MALI	*	OUN
ary	should a mark umatt	은	19a. Informant's Name/Relationship ( <i>Type, Print</i> )  19b. Mailing Address ( <i>Street and Number or R</i>			
Ž,	is 1 and 2 of Health a Item 27 le other trai		Joanne Calhoun / Wife 328 Braddock Street,	APT. 211	FROSTBU	RG, MD 21532
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Items 23e or 28a-f show any injury or other traumatic svent, the Medical Expiritive inval by inclined at an analysis and once.		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)	3/21/05	20c. Location - City	
Ħ	artmer artmer ortant injury		` 4 □ Donation 5 □ Other (Specify) ROCKLY GAP VETERANS CEM  21. Signature of Funeral Service Licensee 22. Name and Address of Facility	1	LINTSTON	E, MD IN STREET
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			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardinations, or heart failure. List only one cause on each line.		est,	Approximate Interval Between
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V	and transi	Examiner	cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):			
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	tificate ig phy as the	tedlo	d.			
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$\equiv$	Attending Physician: ir death. ector: After this certifice by the funeral director.	0 B	examiner?	eath <i>(Check only on</i> Home 5 \subseteq Reside		Specify)
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<u>&gt;</u>	al or A after a Direct d in by	Certification;	4 Homicide	City or Town		Rural Route Number,
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: Atter this certificate his completely filled in by the funeral director, page	edical	29a. Certifier (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place.	ce, and due to the ca	use(s) and manner	as stated.
	the F thin 24 the F mplete	Medi	one) and manner stated.  29b. Signature and title of certifier 29c. License number		Od. Date signed (Me	
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	OU		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	- ()	1 12	2003
	411		Jesus H. Jan M.D. Frostburg Plaza, F	rostbur	a MD	91229
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature MAR 2 4 2005		Ĭ	
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			1 - State Registrar	of Maryl		artment of I		d Mental Hy	Reg. N	-	)	00	67
	Physici		Decedent's Name (First, Middle, Last)     Ronald David Cipolla					2. Date of D Month March	Da	ay Y	ear ea	3. Time o	
	/Medio Examin		4a. Facility Name (If not institution, give street and r Montgomery Hospice-Ca		ouse	4b. City, Town, o	or Location of De			County of Monte		L	Р
	Funeral Director		5. Social Security Number 172-30-7480 6. Sex 12 M 2 F	7. Age (In )	vrs. last birthday) 8 Yrs.	If Under 1 Year Months Days		lin. (Month, D	irth lay, Year 19,	1936	Birthpl Count Penn	ace (State try) isylva	or Foreign nia
	e Maryland a-f ehow iified at	ctor	10a State 10b. County Maryland Montgomery	10c.	City, Town or Lo						10	0d. Inside C	City Limits 2 1 No
	with the	I Director	10e. Street and Number  2 Boxelder Court			10f. Zip Code	853		10g. C	itizen of Wha	at Count	ry?	
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, Mary	and 2 shou alth and M 27 le mai er treumai		19a. Informant's Name/Relationship (Type, Print) Ruth Cipolla/ Wife					Rural Route Numb			ate, Zip (	Code)	
more	Pages 1 and of He and or other		20a. Method of Disposition  1 № Burial 2 □ Cremation 3 □ Removal from  '4 □ Donation 5 □ Other (Specify)	State		sition (Name of natory or other plan aven Cemete	, Ind	Date rch 10,		ocation - Cit			bnelv
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			30. Name and address of person who completed car Charles Harrison, M.D.	. 60	01 Munca	ster Mil	1 Road,	Rockvil	le,	MD 208	355		
	Sta Registra		31. Date filed (Month, Day, Year) MAR 0 9 2005 32	Registrar's Sig	gnature Ap	who							

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			Registrar  1. Decedent's Name (First, Middle	(ast)		erinicate or i	Dealli	2. Date of Deat	eg. No. UU	3. Time of Death
п	Physici	an	CECILIA	MARIE	COLL	1115		Month	Day Ye	par Du
	/Medic Examir		4a. Facility Name (If not institution			4b, City, Town, or	r Location of Deat	D 3	4c. County of [	- 1
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	Funeral		5. Social Security Number	6. Sex 7. Age	e (In yrs. last birtho	(ay) If Under 1 Year	If Under 24 Hrs		9.	Birthplace (State or Foreign
	Director		None	1 ☐ M 2 🖾 F	O Yrs	Months Days	Hours Min.	March 2		Maryland
	<u>p</u>		Usual Residence of Decedent							
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	be filed within 72 hours after death with the Maryland ital Hygiene. id other than "natural", or Items 23e or 28e-f show event, The Medical Examination in this is a second.		10e. Street and Number 4309 Millwood	od Road		10f. Zip Code 21771		10	og. Citizen of Wha U.S.	•
	ems ems	Funerai	11. Marital Status	12. Was Decedent 8 Armed Forces?	Ever in U.S.	13. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (S	Specify Yes or No-		American Indian, Vhite, etc.
36	or It	by Fu	1 Never Married 2 Marri	ed 1 ☐ Yes 2 🔼 N If Yes, Give	10	1 ☐ Yes 2 🖾 No	Specify:	,,	Specify:	White
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Maryland 21215-0036	T1 = 20 ()	To Be	John Patrick	Collins, IV				na Sue Ar		
	ss 1 and 2 should of Health and Me item 27 Is mark cother treumation		John P. Collins Dana Sue Collins			lailing Address (Street a			-	
ře,	s 1 and 2 of Health item 27		20a. Method of Disposition	_	20b. Place of Di	isposition (Name of crematory or other place	·a)		20c. Location - City	or Town, State
E	Page Int: #		1 Burial 2 □ Cremation  '4 □ Donation 5 □ Other (Sp			Heaven Cemete	TIGIL	ch 8 005 - S	Silver Sp	ring, Maryland
Baltimore,	permit. Pages 1 Department of H Important: If its any injury or ot once.		21. Signature of Funeral Service I	icensee		22. Name and Address Francis J. 500 Univer	s Collins sity Bly	Funeral	Home Inc ilver Spr	ing, MD 20901
			23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that caused	the death. Do not			· · · · · · · · · · · · · · · · · · ·		Approximate
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Division	or Al after of Dirac in by	ertification;	4 Homicide determi	building, etc	iry - At nome, farm, :. (Specify)	street, factory, office		City or Town,		Rural Route Number,
-	To the Hospital or Attendi within 24 hours after death.  To the Funeral Director: A completely filled in by the fu	O	29a. Certifier 1 Certifying (Check only 2 Medical E	Physician: To the best of	of my knowledge, d	eath occurred at the tim	ne, date and place	, and due to the ca	use(s) and manne	as stated.
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			30. Name and address of person v	no co pleted cause of de	eath (Item 23a) (Ty	pe, Print)	NIECT	RA-	712845	4023
						A 0	- 0 = )1	1 MILLI	INNOKE	111/201
	Sta Registr		31. Date filed (Month, Day, Year) MAR 0 9	32 Registra	r's Signature	perter				

			For State Registrar	State of Maryla		artment of F			iene 005	10069
	Division		1. Decedent's Name (First, Middle, Last,					2. Date of Deat Month	n	3. Time of Death
	Physici /Medio		Patrick Khoon-	Heng Chec	ok			March 4	1, Day 2005	9:45 P M
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	Funeral Director		213-72-9491	9tM 2□ E	s. last birthday)	Months Days	Hours Min		Year)	Birthplace (State or Foreign Country) ingapore
	land ow		Usual Residence of Decedent  10a. State  10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits
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	r 28a	Director	10. 01 111	pshire Circle		10f. Zip Code	20070	10	g. Citizen of Wha	at Country?
	th wit			P.S.1.2.0 011010			20878		US	A
980	d within 72 hours after death with the Maryland Jiene. r than "natural", or Items 23a or 28a-1 show the Medical Examinat must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3X Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2🎛 No	ispanic Origin? (S in, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)		American Indian, White, etc. Asian
21215-0036	within 72 ho ene. than "natur	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done o DO NDT use retired	during most of wa	orking	16b. Kind of Busin Retai	ess/Industry L
Maryland 2	e filed al Hyg othe vent.	To Be Co	17. Father's Name (First, Middle, Last) John Cheok					me (First, Middle, M ne Lim	faiden Sumame)	
	and 2 shore alth and h		19a. Informant's Name/Relationship (Ty Michael C. Chec		19b. Mailir 21	ng Address <i>(Street a</i> 737 Brink	and Number or Ri Meadow	ural Route Number, Lane, Ger	City or Town, Sta	nte, <i>Zip Cod</i> e) , MD 20876
Baltimore,	permit. Pages 1 and 2 should b Department of Health and Ments Important: If item 27 is marked any injury or other traumatic e	j	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F  4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	cemetery, crer	sition (Name of matory or other place even Cemete		ch 8,	Oc. Location · City	y or Town, State
Balti	permit. Departn Imports any inju		21. Signature of Funeral Service Licens	ee Ocale	F1 50	Name and Address Cancis J. O Univer	ss of Facility			ing, MD 20901
	cate be executed /Medical bysician and the burial-transit	dicai Examiner	23a. Part 1. Enter the disease, or complishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		: Lympha equence of):	atic Leuk		c or respiratory arre	St,	Approximate Interval Between Cnset and Death 4 Years
.O. Box 68	that the death certifica led by the attending ph detached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregr 1 □Live birth 2 □ Fel 4 □ Pregnant at time of 9 □ Unknown	tal death 3□	Ectopic pregnancy Other (specify)			23d. Date of Month	f delivery Day Year
٥.	es ign be	by	Part II. Other significant conditions cor	ntributing to death but not re	sulting in the u	nderlying cause give	en in Part I.			te to the cause of death?
al Records,	The law ate has b page 2 sl	Completed						24a. Was an autopsy perform 1 Yes 2	prior deat	e autopsy findings available to completion of cause of h? Yes 2 \sum No
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Oth		ath Check onl one		
of	ing Phys n. After this funeral dii	ion: To	27. Manner of Death 1 Natural 5 Pending	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at at	lome 5 Resider 28d. Describe ho		Specify)
=	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury · At I building, etc. (Spec	nome, farm, str ify)			28f. Location (Str. City or Town,		or Rural Route Number,
	To the Hospital within 24 hours a To the Funeral Completely filled i	Medicai C	29a. Certifier 1 Certifying Physical Control (Check only one) 2 Medical Exami	sician: To the best of my kn ner: On the basis of examin and manner stated.	owledge, death ation and/or in	occurred at the time vestigation, in my op	ne, date and place pinion, death occu	e, and due to the ca urred at the time, da	use(s) and manne te and place, and	or as stated. due to the cause(s)
	To th within To th comp	Me	29b. Signature and tilte of certifier	1		29c. License	number	29	d. Date signed (N	fonth, Day, Year)
			( QM )	1 en Lan	,	DF	7 P P 0 4	) , (	3/08/	2005
	15		30. Name and address of person who co Ceri Yen-Kan, M				Gaithers	ourg, MD	20877	
	Sta Registr		31. Date filed (Month, Day, Year) MAR 0 9 20	32 Registrar's Sign	ature Ap	arli				

			For State Registrar	8	State o	of Mary	yland			nt of H te of L	ealth and Death	Mental H	ygien Røg. Nj	and any order	10070
			1. Decedent's Name (First, Middle,	Last)								2. Date of D	eath Da	y Yeer	3. Time of Death
	Physici		Anthony Le	vin	Cap	ers						03	10		1907 PM
	/Medic Examin		4a. Facility Name (If not institution,						4b. City	, Town, or	Location of Deat	th	40	. County of Dea	th
	CAGITIII		Peninsula legi	inan	Nen	1:cal	100	4-		Salis	Sburd			Wicon	Dico.
-	Funeral		5. Social Security Number	6. Sex	IIRCI	7. Age (I.	in yrs. ias	t birthday)		r 1 Year	If Under 24 Hrs	8. Date of E	Birth	9 Bir	thplace (State or Foreign ountry)
	Director		174-52-2300	1 JE M	1 2 🗆 F	43		Yrs.	Months	Days	Hours Min	Aug. 1	Day, Year 5.196	1 Was	hington,D.C.
			Usual Residence of Decedent												
	/land		10a. State 10b. County			10	Oc. City, 1	Town or Lo	cation						10d. Inside City Limits
	Man	ţō	Maryland Carol	ino			Gree	ensbor	ro						1 ☐ Yes 2 ☐ No
	the 28a	Director	Maryland Carol  10e. Street and Number	THE			OLCC	.110001	_	p Code			10g. C	itizen of What C	ountry?
	with se or		EOO Tool Cine	.1.						21639				USA	
	d within 72 hours after death with the Maryland Jiene. I then "natural", or Items 23a or 28a-f ehow Ite Medical Exactivat routified at	Funeral	502 Teal Circ	1	. Was Dec	edent Eve	er in U.S.	13. \				Specify Yes or I	VO-	14. Race - Am	erican Indian,
	lten Ren	Ę.	1 Never Married 2 Marri		Armed F	orces? 2 ZNo			f Yes, sp	ecify Cuba	ispanic Origin? (5 n, Mexican, Puer	to Rican, etc.)		Black, Whi	te, etc.
9	rs af	by	3 ☐ Widowed 4 ☐ Divorced		If Yes, G Year or I	ive			1 🗆 Yes	2 No	Specify:			Specify: P	lack
3	hou	pa	15. Decedent	's Educat				16a. Deced	dent's Us	ual Occupa	ation		16b. I	Kind of Business	
9500-612	"na	Completed	(Specify only highes	t grade c	completed			(Give	kind of w	ork done d use retired	during most of wo	orking			,
7	with and the man	E E	Elementary/Secondary (0-12)		College	(1-4or 5+)		Dada.	4 0 20		,		Par	inting/S	elf Employed
Z	filed v Hygie other t		17. Father's Name (First, Middle, I	aetl				Pain	ter_		18. Mother's Na	me /First Midd			EII Empioyed
Maryland	d la b	Be	17. Father's Name (First, Middle, 1	Lasi)										,, camano,	
<u>8</u>	should be ind Menta i marked umatic ev	2	James Capers								Ella	Mille			
<u>a</u>	01 00 00 00		19a. Informant's Name/Relationsh	nip <i>(Type</i>	, Print)				_		and Number or R				
	1 and 2 Health em 27		Ella V. Brown	/ Mot	ther										,Md. 21639
ĕ	thealt Item 2		20a. Method of Disposition	a 🗆 🗅		Charles	20b. Plac	ce of Disponetery, crer	sition (Na natory or	ame of other plac	e)	Date	20c. I	_ocation - City or	Town, State
Ĕ	Page ent c nt: If		Burial 2 Cremation 4 □ Donation 5 □ Other (Se	з ⊔неп рес <i>ify)</i>	novai from	State		itol				18-2005	Dox	ver, Del	aware
Baltimore,	permit. Pages Department of H Importent: If Its eny injury or of		21. Signature of Funeral Service I		12.		Luap.	22	Name	and Addres	ss of Facility			ver, 502	
ñ	Per		1	1			ww.		Ben	nie S	mith Fu	neral H	ome	arvland	21601
			23a. Part1. Enter the disease, or	ecopolica	itions that	caused th	ne death.	Do not ent	er the mo	de of dyin	g, such as cardia	c or respiratory	arrest,	aryrand	Approximate
			shock, or hetart failure. List	only one	cause on	each line.	0.5	-		,	3,	,			Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	a.		A	KU	17							Sdays
	/Medical		resulting in death)		Due to	o (or as a c	conseque	nce of):		,					5 days > Sdays > Sdays
	Examiner		Sequentially list conditions,	b		- 1	en	21	+	cil	UVC				> Sdays
		Examiner	if any, leading to immediate	,	Duø to	o (or as a c	conseque	nce of):		111					
	outec	Ē	that initiated events	C.			TU	ica		ta	ilurc				7 Sdays
<u>_</u>	exe in ar	EX	resulting in death) Last		Due to	o (or as a c	conseque	nce of):							7
8760,	cate be executed physician and the burial-transit	dical		d			-	<u> 11 V</u>							
8						4.40									
×	death certifii e attending p ad for use as	N	IF FEMALE: 23b. Was decedent pregnant	230		utcome of								23d. Date of de	elivery
Box	atter for u	Physician/M	in the past 12 months?			birth 2			□Ectopic □ Other (	pregnancy s <i>pecify</i> )	1			Month	Day Year
o.	0 0 0	ysle	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		9□ Unk				,						
О.	The law requires that the de tte has been signed by the a page 2 should be detached	-F	Part II. Other significant condition	ns contr	ibutina to	death but	not result	ing in the u	nderlying	cause giv	en in Part I.	23e. Di	d tobacco	use contribute	to the cause of death?
Records,	res t signe be d	by	Takin outer organical						,,	<b>3</b>		11	∃ Yes	2□No 3□E	robably 4 Linknown
20	equi	Completed													
ပ္ပ	law r	ple										24a. W	as an topsy	prior to	utopsy findings available completion of cause of
ř	hysician: The law his certificate has t I director, page 2 s	E										pe 1 ☐ Yes	rformed?	death? lo 1 ☐ Ye	s 2 No
ta		a)	25. Was case referred to medical	17							26. Place of De	eath Check on			
Division of Vital	Physician: r this certificaral director, I	OB	examiner? 1 ☐ Yes 2 Solo		spital: 1'S	Inpatient	2□€	R/Outpatier	nt 3 🗆 (	Oth	05			6 □Other (Sp	ecify)
ō	Phy rald	<b>}</b>	27. Manner of Death		28a. Dat	e of Injury	2	8b. Time o		28c. Injur Wor				ury occurred	
O	ding I	tlor	yatural 5 ☐ Pendin		(Mo	nth, Day Y	Year)	Injury	М		k? Yes 2 □No				
S	i or Attending Ph after death. Director: After th I in by the funeral	Certification:	3 Suicide 6 Could	not be	28e Pla	ce of Injun	v - At hom	e, farm, st	reet facti	nry office		28f. Location	(Street	and Number or F	Rural Route Number,
2	or A lifter Direction by	Ħ	4 - Homicide determ	inea	buil	ding, etc.	(Specify)	,		лу, отпос		City or	Town, Sta	te)	
ш	Hospital or A 24 hours after Funeral Direction by Stely filled in by	ပိ									4-4			(-)	
	To the Hospital within 24 hours of To the Funeral completely filled	ledical	(Check only 2 Medical	ig Physic Examin <i>e</i>	r: On the	basis of e	xaminatio	ledge, deat on and/or in	n occurre vestigati	on, in my o	me, date and plac pinion, death occ	ce, and due to t curred at the tim	ne cause e, date a	s) and manner a nd place, and du	is stated. ie to the cause(s)
	the lin 2	ed	one)		and ma	inner state	ed.						004.5	Nata -1 (1/2-	At Day Varia
	To the Hospital within 24 hours a To the Funeral I completely filled	Σ	29b. Signature and title of certifie	г					2	9c. Licens		_		ate signed (Mor	mi, Day, rearj
			1,00	m	en	Q				H	OOLE	327		3/11/0	5
	( = i		30. Name and address of person	who com	pleted ca	use of dea	ath (Item 2	23a) (Type,	Print)					, ,	
(	31			E.	ZIEM	101,	M.O.	100	E.	MAKK	00 GI	SALIS	bury	Mb.	2/80/
	St	ate		2005	37	Registrar	's Signatu	гө							
	Regist		MAKTO	EUUJ		1000		A Section	Self?	<u> </u>					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2005 Month Year **Physician** March 11, 2:30 a Chesnut Clinton /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner St. Mary's Nursing Center St. Mary's Leonardtown If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Sept. 21, Birthplece (State or Foreign Country)
 Oklahoma 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Year) 1**X** M 2 □ F 1918 543-07-1319 86 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State ? Is marked other than "natural", or Items 23a or 28a-f show traumatic svent, the Modical Examinar must be notified at 1 ☐ Yes 2 No Directo St. Mary's Lexington Park Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 20653 412 Great Mills Road Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? filed within 72 hours after 1 Never Married 2 ☐ Married If Yes, Give 1942 Year or Dates: 1947 White Baltimore. Maryland 21215-0036 1 ☐ Yes 25 No Specify Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Civil Service Electronics Tech 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fil ment of Health and Mental H tant: If item 27 Is marked ott Be Chestnut Chesnut Anna Margret Stanley Orwell ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 141, Tall Timbers, Maryland 20690 Elizabeth Morris/Personal Rep. other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
sny injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State Maryland Veterans Cem 3/18/2005 Cheltenham, Maryland 4 □ Donation 5 □ Other (Specify) Signed Funeral Service Licensee
Edward N. Brinsfield, 22. Name and Address of Facility rinsfield Funeral Home, P. Maryland 20650 Jr. Approximate Interval Between Onset and Deul 23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each sed the death Do not enter the mode of dving. Immediate Cause (Final Physician disease or condition resulting in death) monde /Medical **Examiner** 2000 1700 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exar iner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): P.O. Box 68760. Physician/Medical e attending physical as the b 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9□ Unknown 9 Unknown signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. vision of Vital Records. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ■Unknown 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performed? 2 8 No 1 Yes 2 No 1 TYes 25. Was case referred to medical examiner? director. Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ۵ 1 Yes 2 No 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: Hospital or Attending 5 Pending investigation 1 Natural s after dec. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicet Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and litle D 06419 person who complete cause of death (Item 23a) (Type, Print) 30. Name and address Leonardtown, Maryland 20650 Jarboe, M.D. James gistrar's Signature State MAR 1 6 2005 Registrar

State of Maryland / Department of Health and Mental Hygien® 1 - For State Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year Henrietta Cecelia Countess 5:35 P M /Medical March 11. 2005 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Clinton Nursing and Rehabilitation Center Clinton Prince Georges 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1 □ M XXF Director 215-26-0793 Oct. 22, 1909 Pennsylvania Usual Residence of Decedent show! 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic avant, the Midles! Examiner must be multiply at Director Maryland Charles 1 ☐ Yes 2XXNo 28a-f Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ or Itams 23a 3047D October Place 20602 Funeral USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2XX No þ 3 Widowed 4 □ Divorced Specify. Black Completed Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) s 1 and 2 should be filad with Health and Mental Hygien Itam 27 is markad othar th Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Daniel Cornelius Nelson ပ Mary Ellen Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If itam 27 is any injury or othar tra Martha C. Daniels/ Daughter 6911 Groveton Drive, Clinton, MD 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State March 17, 2005 Leonardtown, Maryland Charles Memorial Gardens \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Ligensee 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P P.O. Box 270, Leonardtown, MD 20650 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Myocardi disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed anding physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of); Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. I 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy Per phero/ 25. Was case referred to medical examiner? 2∏ No 1 Yes 2 🛣 No 1 Tes 26. Place of Death (Check only one. Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 ☐ Yes 2 No 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 ANatural 5 Pending within 24 hours after death. To tha Funeral Diractor: A investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai completely To tha 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1 mgs 200 37066 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6/88 0 x0n /till hoad # 70/ Whethir T. Opargo eogy, m.o. oxon /till moo 26 7 45 31. Date filed (Month, Day, Year) 32 Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

			1 - For State Registrar	State of M	laryland /		artment o			Mental Hy	giene	6002	10073
	O		1. Decedent's Name (First, Middle,	Last)						2. Date of De		. V	3. Time of Death
	Physic /Medi		GRACIE	COX						March	L 4,		10:50AM
	Exami		4a. Facility Name (If not institution,	give street and number			4b. City, To	wn, or Locat	tion of Deat	h	40	. County of Death	
			Randolph Hil	ls Nursin	g Home	3	W	heato			M	lontgome	ery
	Funeral		5. Social Security Number 6	3. Sex 7. A 1 ☐ M 2€ F	ge (In yrs. last l		If Under 1 Y Months D	ear If Ur ays Hou	nder 24 Hrs urs Min.		th v. Year	9. Birthi	place (State or Foreign
	Director		417-36-1914 Usual Residence of Decedent	12.11	78	Yrs.				Jan 3	,19	27 Alak	pama
	and		10a. State 10b. County		10c. City, To	wn or Lo	cation						I Od. Inside City Limits
	Mary f aho jed a	ō	MD Monto		G. I		G						1 XYes 2 □ No
	28a	ec	MD Montg  10e. Street and Number	omery	511	ver	Spri				10a Ci	tizen of What Cou	2
	3a ou	Funeral Director	11110 Lumbard	v Rd				2090	1			S.A.	my:
	death ms 2	Jera	11. Marital Status	12. Was Decedent		13. V				pecify Yes or No o Rican, etc.)		14. Race - Americ	can Indian.
9	or its		1 Never Married 2 Marrie							o Rican, etc.)		Black, White,	
93	72 hours after death with the Maryland natural', or Itams 23a or 28a-f ahow Jigal Examiner must be notified at	d by	3 ☐ Widowed 4 ☑ Divorced	If Yes, Give Year or Dates:		1	☐ Yes 200	No Spe	ecify:			SpecifyBlac	:K
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121	d within 7. jiene. r than "n	mpi	Elementary/Secondary (0-12)	College (1-4or	5+)		kind of work a OO NOT use n						_
2			6th 17. Father's Name (First, Middle, La	n ct)		Cus	todia		4			lic Sch	ools
ano	0 = 0 5	Be		•				18. M		ne (First, Middle,			
Ž	2 should be and Mental is marked o	70	Emett Co	OX	10	No. Marifa	- Add (C)			z Mill			
Ma	d 2 s th an th an traur		Gracie Gaddis									or Town, State, Zip	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Itam 27 is marked any injury or other traumatic as once.		20a. Method of Disposition	111000			sition (Name o		1	Date		ocation - City or To	
JO L	ages ant of t: If I		1 Burial 2 □ Cremation 3  `4 □ Donation 5 □ Other (Spe		,				2/2	. / ^ =			
量	artme ortar injur		21. Signalure of Funeral Service Lie	7.7	_ MD N		Mem		3/1			Laurel,	ome, P.A.
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			23a. Part1. Enter the disease, or co	omplications that cause	d the death. Do							110, 112	Approximate
	Physician		shock, or heart failure. List or Immediate Cause (Final			20.00	DOME	~~~					Interval Between Onset and Death
	/Medical		disease or condition resulting in death)		EPRAL s a consequence		ARCTI	N					
	Examiner		Conventially list conditions	b									
	p .#	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		a consequence	e of):							
	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c									
8760,	cate be executed physician and the burial-transit		rosetting in doutiny cust	Due to (or as	a consequence	∋ of):							
87	physic the k	Physician/Medical		d									
9 X	death certific e attending p d for use as	/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy								
Вох	atten atten I for u	clan	23b. Was decedent pregnant in the past 12 months?		2 Fetal deat		Ectopic pregn Other (specifi					23d. Date of delive Month	ry Day Year
o.	that the de led by the a detached f	iysi	1 ☐ Yes 2 ☎No 9 ☐ Unknown	9☐ Unknown	a tano or doday	•	Other (apoon)	,,					
S, D	The law requires that the ate has been signed by the page 2 should be detached.		Part II. Other significant conditions	s contributing to death t	out not resulting	in the un	derlying cause	e given in Pa	art I.	23e. Did to	bacco L	use contribute to th	e cause of death?
ğ	w require been sig should b	Completed by	Diabetes Meli	litus Typ	e II		_			101	/es 2	□No 3□Prob	ably 40 Unknown
Vital Record	aw requ s been 2 should	olet	Hypertension							24a. Was	an	24b. Were auto	osy findings available
æ	The fav	E O								autop perfo	isy rmed? 2፟ A No	prior to cor death?	npletion of cause of X□ No
	ian: rtifica stor, p	Φ	25. Was case referred to medical					26. P	lace of Dea	1  Yes th (Check only o		1 ☐ Yes	49LI NO
	Physician: r this certific ral director,	To B	examiner? 1 ☐ Yes 2 <b>X</b> No	Hospital: 1 Inpatio	ent 2 ER/C	utpatient	3 □ DOA	0.4				6 □Other (Specify	•)
0	ng Pt fter tt neral		27. Manner of Death 1 Natural 5 Pending	28a. Date of Inju (Month, Da	ury 28b.	Time of Injury	28c.	Injury at Work?		28d. Describe h			,
<u>Ö</u>	Attending r death. ector: After by the funer	atic	2 ☐ Accident investigat	ion	,	,,		1 ☐ Yes 2	2 □ No				
Division of	l or Att after de Direct I in by t	Certification;	3 ☐ Suicide 6 ☐ Could not determine	ad 286. Place of in	jury - At home, f tc. (Specify)	arm, stre	et, factory, off	ice		28f. Location (S City or Tox	Street an In, State	d Number or Rura	Route Number,
	urs af urs af ural D			1									
	To the Hospital or Attending Physician: The i within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical	29a. Certifier 1 ♣ Certifying (Check only one)	Physician: To the best eminer: On the basis o and manner st	n examination a	ge, death nd/or inve	occurred at the estigation, in r	ne time, date my opinion,	e and place, death occur	and due to the ored at the time, or	cause(s) date and	and manner as st place, and due to	ated. the cause(s)
	within 2 To tha complet	Mec	29b. Signature and title of certifier	And mariner st			29c. Lic	ense numb	190		29d. Dat	e signed (Month, I	Day, Year)
)	->-0		· 11	1) ()	. 1			52261				rch 4,	
	2	-	30. Name and address of person wh	o completed cause of	eath (Item 23a)	(TUDA P							
			Alan R. Seq	/	1299	7		n Dr	Si	llver S	pri	ng, MD	20910
	Sta	te	31. Date filed (Month, Day, Year)		rar's Signature		Mes.		-, 0.		<u></u>	-17 110	20010
	Registr	ar	MAR 101	UIII'S Harre	w B	100	-						

	3		Please I					of Health and	-		_		
			For State	State of Mai	ryland /			of Death	wentai ny	6	GUU.	100	74
			Registrar  1. Decedent's Name (First, Middle, Last)				mouto	Or Bourn	2. Date of D	Reg. No.		3. Time	of Death
	Physici		JOHNIFER A	t. Crui	mmi	tt			8°3	Bay	2 ZOL	5 07:	45 AM
	/Medic Examin		4a. Facility Name (If not institution, give s Dorchester Genera	treet and number)	h	-	/ \	m, or Location of Deat	h		County of De		
-	Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. last b	birthday)	If Under 1 Y	ear If Under 24 Hrs		rth	9. B	rthplace (State	or Foreign
	Director		189-24-7364	M 2 F	73	Yrs.	Months D	ays Hours Min.	Nov. 1		31 Peni	nsylvan	<u>ia</u>
Manyland	Mo. N		10a. State 10b. County		10c. City, To	wn or Loca						10d. Inside	City Limits s 2 ☐ No
$\int_{0}^{\frac{1}{2}}$	8 - 6	ctor	MD Dorches	ter				Cambridge					\$ 2 NO
Ź ŧ	or 28	Director	10e. Street and Number				10f. Zip Co	21613			zen of What ( USA	Country?	
3	s 23e	eral	311 West End Av	E. 12. Was Decedent Ev	ver in U.S.	13 Wa	as Deceden		Specify Yes or N			encan Indian,	
	perfills. Tages I also should be filed within 72 mous after beath with the way year. I happenend of Health and Mental Highene. Inportant: If I tam 27 is marked other than "natural", or Itams 23a or 28a-1 show any injury or other traumetic event, I a Medical Evanitation must be notified at once.	y Funeral	1 Never Married 2 Married	Armed Forces?  1 Yes 2 No If Yes, Give			Yes, specify ☐ Yes 2	t of Hispanic Origin? (S Cuban, Mexican, Puer (No Specify:	to Rican, etc.)		Black, Who	ite, etc. white	
0-0030	iurai',	d by	3 Widowed 4 □ Divorced  15. Decedent's Educ	Year or Dates:	16	Sa Decede	nt's Usual C	Occupation		16b. Ki	nd of Busines	s/Industry	
3 <u>0</u>	"na" r	Completed	(Specify only highest grade	completed)  College (1-4or 5+		(Give ki	ind of work of O NOT use i	tone during most of wo	rking			,	
7 7	r tha	mo	Elementary/Secondary (0-12)	College (1-401 5+		b	ookke				tail sa	ales	
<b>D</b>	al Hy	BeC	17. Father's Name (First, Middle, Last)					18. Mother's Na			Sumame)		
yiand	Ment Brkac efic	ပ္	James Dixon Nau						œth Fri		- T Class	7i- Cadal	
Mar	h and 7 is m traum		19a. Informant's Name/Relationship (Ty) Lisa Crummitt	daughter				nd Ave., C		-	2161.	_	
<b>6</b>	Healt Sam 2 Sthar		20a. Method of Disposition	daugneer	20b. Place	of Disposit	tion /Name	of	Date		cation - City o		
פַ פַ	ages ant of it: If it y or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Our L	ady c	T GOO	d 3/	16/05	Se	cretary	, MD	
Baitimore,	oortar injur		21. Signature of Funeral Service License	96	Couns	el Ch	Name and	ard Address of Facility T	nomas Fu	inera	1 Home	P.A.	
ö	Depa Impo any is		I thus lon			70	00  Loc	ust St., C	ambridge	e, MD	2161:	3	
	hysician /Medical xaminer		23a. Part. Enter the disease, or complishood or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused to cause on each line.  Due to (or as a	ic In	utorc	the mode of	Myocordia	c Tuf	arrest,	ON	Approxim Interval B Onset and	etween
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O. Box 68	ine ray requires mar me deam cerimicate. Ite has been signed by the attending physioage 2 should be detached for use as the t	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 2 No 9 □ Unknown	3c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	Petal dea		Ectopic preg Other (spec				23d. Date of d Month	elivery Day	Year
ر. ح	wrequires matine as been signed by the should be detached		Part II. Other significant conditions cor	ntributing to death but	t not resulting	g in the und	derlying caus	se given in Part I.				to the cause of	
r d	en siç en siç	ted	Congestive Mea	rt Pailur	દ				1_	Yes 2	No 3□	Probably 4	JUNKNOWN
Vital Records,	siciant: The law of certificate has be irector, page 2 sh	Completed by	Great Carer				-		24a. Wa auto per 1 ☐ Yes	s an opsy formed? 21 No		autopsy finding completion of as 2 No	
		Be C	25. Was case referred to medical					26. Place of De	eath (Check only	14			
> io	nysician: nis certifica I director,	To E	examiner? 1 ☐ Yes 2 ANo	lospital:	t 2 ER/	Outpatient			Home 5 ☐ Res			ecify)	
ס ניס	th. After this funeral o		27. Manner of Death  1 SNatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day		o. Time of Injury	M 28c	Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe	how injui	y occurred		
Division	to the hospital or Attending Priystcian, within 24 hours after death.  To tha Funaral Director: After this certifica completely filled in by the funeral director,	Certification	3 Suicide 6 Could not be determined	28e. Place of Inju- building, etc.	ry - At home, (Specify)	, farm, stree	et, factory, c	ffice	28f. Location City or To	(Street ar	d Number or i	Rural Route Nu	mber,
	To the hospitation within 24 hours after To the Funarat Discompletely filled in	edical (	29a. Certifier 1 Certifying Phy (Check only one) 2 Medicel Exemi	sician: To the best of ner: On the basis of and manner stat	examination	dge, death of and/or inve	occurred at estigation, in	the time, date and place my opinion, death occ	e, and due to the curred at the time	e cause(s) e, date and	and manner d place, and d	as stated. ue to the cause	(s)
	within 2 To that complet	Me	29b. Signature and title of certifier	[1.1	-	park	29c. L	icense number	-	29d. Da	te signed (Mo	nth, Day, Year)	
Į.			· will	www	W		V	106106		<u></u>	109	1000	>
			30. Name and address of person who co	Amaier F	1.0.	50	Print) BU	JOG 187	Cambri	dje,	MO	2/613	
Ť	Sta		31. Date filed (Month, Day, Year) MAR 1 4	2005 Regista	r's Signature	Je.	Por A						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item#8, perFH, G841, 3/24/05 TT

			For State Registrar	State of Mary	-	artment of Hea rtificate of De			ene g. Non O o E	10075
	- 1 4 E	#h	Decedent's Name (First, Middle, Last	)				2. Date of Death		3. Time of Death
	Physici			T - D	_			Month March	Day Year 12. 2005	6:00 P M
1	/Medic Examin		4a. Facility Name (If not institution, give	Lee Downe:	S	4b. City, Town, or Lo		Har CII	4c. County of Death	
A.V.	Examili	er			nc	Denton			Caroli	ne
- 53	S. Francis	1 .	Caroline Nursin 5. Social Security Number 6. Se	x 7. Age (In	yrs. last birthday)	If Under 1 Year If	Under 24 Hrs.	8. Date of Birth	9. Birtho	place (State or Foreign
	Funeral Director		214-36-5327	□ M 2□ <b>X</b> F	70 Yrs.	Months Days	Hours Min.	8/19/19		ryland
			Usual Residence of Decedent		7.0					
	yland wow		10a. State 10b. County	100	c. City, Town or L	ocation			1	Od. Inside City Limits
	Mar Mar	to	Maryland Carolin	ne l	Ridg	elv				1 ☐ Yes 2 ☐ No
	7 28g	Director	10e. Street and Number			10f. Zip Code			g. Citizen of What Cou	
	3a o		12853 Crouse Mill	Road		21660		U	Inited State	es oi America
	d within 72 hours after death with the Maryland Jiene, r than "natural", or tems 23a or 28a-1 show The Medicul Examination colling at	Funeral	11. Marital Status	12. Was Decedent Ever	in U.S. 13.	Was Decedent of Hispa II Yes, specify Cuban, I	anic Origin? (Spec	ofy Yes or No-	14. Race - Americ Black, White,	can Indian,
(0	or Ita	F	1 Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give				1041, 610.)		aic.
Ö	el', c	by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		105 20,40	Specify:		Specify: Caucas	ian
21215-0036	72 ho	Completed	15. Decedent's Edi (Specify only highest grad	ucation	16a. Dece	dent's Usual Occupation kind of work done duri	on ina most of workin	a 1	6b. Kind of Business/In	dustry
21	within 7 ene. than "r	ple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired)			Food Proce	essing
21	d wit	0	12		Lin	e Worker				
	be filed tal Hygie od other	Be (	17. Father's Name (First, Middle, Last)			18	3. Mother's Name	(First, Middle, M	laiden Sumame)	
<u>a</u>	ould be Mental narked natic ev	10	Norman (	Crossley Dow	mes		Ola E	mma Star	key	
Maryland	ges 1 and 2 should t of Health and Mer If item 27 is marks or other traumatic		19a. Informant's Name/Relationship (T	ype, Print)					City or Town, State, Zip	Code)
	1 and 2 Health (am 27 I		Mary Ellen Downes			ox 333, Rid	dgely, Ma		21660	
re,	of He itam		20a. Method of Disposition	21	<ol> <li>Place of Disponentery, cre</li> </ol>	osition (Name of matory or other place)	Da	ite 2	0c. Location - City or To	own, State
Ë	Pages nent of I ant: If its ury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specify)	Memoval from State		nt Cemetery	y 3/16/2	2005 H	illsboro, N	Maryland
Baltimore,	그는 근 근		21. Signature of Juneral Service Ligens		the state of the s	2. Name and Address of Moore Funer		Dλ		21629
Ö	Depa Impo any ii	5 2	Kaucon	11/100	~	MOOLE runei	Second	Street	Denton	
	\$ \$1.4		23a. Part 1. Enter the disease of comp shock, or heart failure. List only of	dications that caused the	death. Do not en	ter the mode of dying,	such as cardiac or	respiratory arre	st,	Approximate Interval Between
	Dhusisian		Immediate Cause (Final	ne cause on each line.						Onset and Death
15	Physician /Medical		disease or condition resulting in death)	Due to (or as a co		vative	IDIMON	ary 1	ISEESE	years_
r	Examiner			Dag (0 (0) as a co.	nisoquonoo oi).			•		
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	ted nsit	ulu	cause. Enter Underlying Cause (Disease or injury							
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8760,	cate be executed physician and the burial-transit	alE								
87	E & &	dical	•	d						
9 X	The law requires that the death certifinate has been signed by the attending I bage 2 should be detached for use as	/Me	IF FEMALE:	23c. If yes, outcome of pr	regnancy				23d. Date of deliv	erv
Box	atten for us	Physiclan/M	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 4 Pregnant at time	Fetal death 3	□Ectopic pregnancy □ Other (specify)			Month	Day Year
o.	the the	sic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9 Unknown	o doain o					
<u>o</u> .	that the de led by the a detached i		Part II. Other significant conditions co	ontributing to death but no	ot resulting in the	underlying cause given	in Part I.	23e. Did tob	acco use contribute to t	he cause of death?
écords,	signe	by		•		, ,		1 1 1	s 2 No 3 Prol	oably 4 Unknown
.6	w require been si should t	Completed								
e G	has b	de						24a. Was an autopsy	prior to co	opsy findings available impletion of cause of
H		ő						perform 1 Yes 2	No 1 ☐ Yes	2□ No
Vita	Physician: Th this certificate ral director, pag	Be (	25. Was case referred to medical examiner?				6. Place of Death	(Chack only one	9)	
₹ 50	w ==	2	1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient	2 ER/Outpatie				nce 6 Other (Speci	(y)
	ding Phy h. After this funeral c	ü	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injury (Month, Day Ye	ar) 28b. Time (	of 28c, Injury at Work?	t 2	8d. Describe ho	w injury occurred	
Division	Attending in death.	atle	2 Accident investigation			M 1 TYe	s 2 No			
<u>&lt;</u>	or Attend after death Director:	tific	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S	At home, farm, s	treet, factory, office	2	8f. Location (Str City or Town,	eet and Number or Run , State)	al Route Number,
Ö	s after al Direct	Certification;								
	ospit hour uner		29a. Certifier 1 Certifying Ph	ysician: To the best of miner: On the basis of exa	y knowledge, dea	th occurred at the time,	date and place, a	nd due to the ca	use(s) and manner as s	stated. o the cause(s)
	To the Hospitel or Att within 24 hours after d To the Funeral Direct completely filled in by	Medical	one)	and manner stated.						
	To t withi To t	ž	29b. Signal are and title of certifier	20	1 4	29c. License n	number	29	d. Date signed (Month,	Uay, Year)
		4	James !	roles	- 17	D31	1376		3-14-0	5
			30. Name and address of person who	completed cause of death	n (Item 23a) Type	, Print)		1	. /	)
			Janes Sil	25 MD 9	20 Ma	Met ?	ot D	ento	N MA	21629
	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's	Signature					,
	Regist	rar	MAD 1 4 200	180 mars	18 An					

		• •	ryland / Depa	artment of Health ar rtificate of Death	nd Mental Hygie	ene 1. No. 2005-10076
	ician dical niner	Decedent's Name (First, Middle, Last)     TRMAZELL DINNING     4a. Fecility Name (If not institution, give street and number)     23 WELSH STREET		4b. City, Town, or Location of FROSTBURG	2. Date of Death Month	Day, Oyear 3. Time of Country of Death ALLEGANY
Funer Direct			(In yrs. last birthday) Yrs.	if Under 1 Year If Under 24 Months Days Hours	Hrs. 8. Date of Birth (Month, Day, Y	Q C OKLAHOMA
IN Z 1 Z 15-0030  filed within 72 hours after death with the Maryland Hygiene.  Hydiene.  The than "naturat, or liems 23e or 28e-1 show ant, the Model Example and the	Comp	10a. State 10b. County  MARYLAND ALLEGANY  10e. Street and Number  23 WELSH STREET  11. Marital Status 12. Was Decedent E Armed Forces?  1 Never Married 2 Married 11 Yes 2 Xec	16a. Dece (Give life.	AG  10f. Zip Code  21532  Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, If Yes 2 X No Specify:  dent's Usual Occupation kind of work done during most of DO NOT use retired)  UTICIAN	1? (Specify Yes or No- Puerto Rican, etc.)	10d. Inside City Limits  1 ★ Yes 2 □ No  12. Citizen of What Country?  U.S.  14. Race - American Indian, Black, White, etc.  Specify: WHITE  Sb. Kind of Business/Industry  BEAUTY SHOP
ad la po	To Be			B ang Address (Street and Number	ESSIE EQUHAL or Rural Route Number, C	RDT MOORE City or Town, State, Zip Code)
Te, IV 1 and 1 Health tem 27		JOHN DINNING / SON  20a. Method of Disposition  1 □ Burial 2 🛣 Cremation 3 □ Removal from State	20b. Place of Dispo cemetery, crea	osition (Name of matory or other place)	Date 20	SAVAGE, MD 21545  C. Location - City or Town, State
Baltimor permit. Pages Dep riment of Important: If it	once	*4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee	23	ERLAND CREMATOR 2. Name and Address of Facility OWERS FUNERAL F.	***************************************	UMBERLAND, MD 60 W. MAIN ST. FROSTBURG, MD 21532
(60)  (e be executed  Yield and  Signal an	al er	23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Last Complex Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a Due to (or as a Due to (or as a Cause (Disease or injury that initiated events resulting in death) Last	the death. Do not ene.  a consequence of):  a consequence of):		ardiac or respiratory arres	Approximate Interval Between Onset and Death Howks  Years
the death certificative attending phacehold for use as if	nvsician/Med		2 Fetal death 3 [ time of death 5 [	□Ectopic pregnancy □ Other (specify)	00. 8/44/4	23d. Date of delivery  Month Day Year
Hecords, Phe law requires that share been signed to 2 should be detailed.	eted	Part II. Other significant conditions contributing to death but Chrimic obstructive			1 ☐ Yes	2 No 3 robably 4 Unknown  24b. Were autopsy findings available
	Comp	25. Was case referred to medical			f Death (Check only one)	XNo 1 Tyes 2 No
n of ng Phys	F	1 ☐ Yes 2 No 1 ☐ Inpatier			28d. Describe how	
DIVISION C oltal or Attending P urs after death. oral Director: After illed in by the funers	Certification:				City or Town,	
DIVISION To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical	29a. Certifier (Check only one)  2 Medical Examiner: On the basis of and manner state of certifier	examination and/or in	n occurred at the time, date and investigation, in my opinion, death  29c. License number	occurred at the time, date	e and place, and due to the cause(s)  d. Date signed (Month, Day, Year)
		30. Name and address of person who completed cause of de	eath (Item 23a) (Type.	D2124	4	3/17/2005
	State istrar	Lesus H. Tan M.D	rsSignature/	thurg Plaz	ea, tros	Hourg, MD 21532

State of Maryland / Department of Health and Mental Hygiene 005 For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** March 4, 2005 PM 6:00 Ruth Fentiman Dove /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Mariner Health Nursing Home Montgomery Kensington
If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
July 9, 1921 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Months 1 ☐ M 2 🖸 F 577.26.5391 83 Washington, Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10h County 10a State rel', or items 23a or 28e-f show Examinar must be notified at 1 TYPes 2 □ No MD Montgomery Bethesda Directo 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number 20816 United States 5810 Augusta Lane Funerai tiled within 72 hours after death Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 "neturel", or 1 ☐ Yes 2 No Specify: Specify:White 3√2 Widowed 4 □ Divorced Completed by 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical then College (1-4or 5+) Elementary/Secondary (0-12) Own Home 12 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be tile
Department of Health and Mental Hy
Importent: If item 27 is marked oth
any injury or other treumatic event
once. Sidney Fentiman Mary Fisher 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5810 Augusta Ln., Bethesda, MD 20816 Charles Dove Jr. / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 

Burial 2 □ Cremation 3 □ Removal from State Cedar Hill Cemetery | Mar. 9, 2005 | Suitland, MD 1 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Joseph Gawlers Son's, INC. 5130 Wisconsin Ave. N.W., Washington, DC 20016 MO1378 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. mmediate Cause (Final PNEUMONIA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner HEMORNHAGE GASTROINTESTIMAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certiticate be executed use as the burial-transi and Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown ģ signed b Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2. No 3 ☐ Probably 4 ☐ Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an autopsy perform 1□ Yes 2 INO Physicien: the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 2 2010 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes this 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of injury (Month, Day Year) Certification: To the Hospitel or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined tilled in by 4 Homicide within 24 hours a Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 000 3/7/05 D0057124 s/mD 15 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Truong Bao, 13291 Executive Park Terr., Germantown MD 20874 Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 09 2005 Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2005

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			1 - For State Registrar	State of Mary		rtificate of			g. No.	10010
	Physici	an	Decedent's Name (First, Middle, Last)  ELLI A ELEANOR ELE			13		2. Date of Death Month MARCH 14		3. Time of Death
2	/Medic	al	EULA ELEANOR EL  4a. Facility Name (If not institution, give s			4h City Town o	r Location of Death	MARCH 1	4 2005 4c. County of Death	1:20 P M
ps.	Examin	ier	LIONS MANOR NURSI			LaVALE	LOCATION OF DOLL		ALLEGAN	
	Funeral Director		213 44 0049	7. Age (// 7. 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, APRIL 9	9. Birth <i>Col</i> <b>19</b> 28 WES	nplace (State or Foreign intry) VIRGINIA
	yłand now		Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town or Lo	cation				10d. Inside City Limits
	a Mar	ctor	MARYLAND ALLEGANY		FROSTBUR	G				Y Yes 2 No
	ath with th 23£ or 28 ust be no	Funeral Director	10e. Street and Number 201 WELSH HILL			10f. Zip Code 215			g. Citizen of What Cou	untry?
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene.  od other then "naturel", or items 23c or 28s-f show event. The Modical Exit interferest be notified at	by	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 24 No If Yes, Give Year or Dates:	•	Was Decedent of H f Yes, specify Cuba 1 Pes 2 No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify:	
5-0	72 ho "natur	eted	15. Decedent's Educ (Specify only highest grade	cation completed)	(Give	dent's Usual Occup	during most of work	ing 1	6b. Kind of Business/I	ndustry
121	filad within Hygiene. othar than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired OMEMAKER	1)		OWN HOME	7
	e filad al Hygie I othar vant.	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nam		aiden Sumame)	
ylaı	2 should be tand Mantal I is marked of sumatic eve	10	ISAAC MILLER	141				IE COSNEI		
Maryland	5 5 5 5 5 5 G		19a. Informant's Name/Relationship (Ty)  JOSEPH FAZENBAKER		1		LL, FROS		City or Town, State, Zi	ip Code)
Baltimore,	a 0		20a. Method of Disposition  1 X Burial 2 ☐ Cremation 3 ☐ R  4 ☐ Donation 5 ☐ Other (Specify)	2	20b. Place of Dispo	sition (Name of natory or other place	ee)		Oc. Location - City or T	
altir	parmit. Pagas Department of Importent: If it any injury or c		21. Signature of Funeral Service Ligense	96		. Name and Addres		7717,03	60 W. MAIN	
<u>m</u>	a G E E G		1/ Carlou 1/	Xowers			ERAL HOMI		FROSTBURG,	
	Physician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line.	mia	er the mode of dyin	g, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
	Examiner		Sequentially list conditions If P	•						`
V	ed sit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	ensequence of):					
e0° ×	i ba axacuted sician and burial-transit	ai Examiner	that initiated events resulting in death) Last	Due to (or as a co	onsequence of):					
68760,	tificata b ig physi as tha b	Medicai	0							
O. Box	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burral-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of p 1 Live birth 2 L 4 Pregnant at time 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	411		23d. Date of deliv Month	rery Day Year
ds, P.	juiras that i n signed by ild ba data	by	Part II. Other significant conditions con RECENT Left					23e. Did toba	acco use contribute to to	the cause of death?
of Vital Records,	l law raqu	ompleted	RECENT Left DIABETIC REN	al Disease	e urll Re	nel FAIL	UKE	24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
alF		O	CORONARY ARTE	ry with Co	repary.	bypass	graf 7.		ZNo 1□Yes	2□ No
Ž	Physician: this certific ral diractor,	o Be	25. Was case referred to medical examiner?  1  Yes 2 No	ospital:	2 ☐ ER/Outpatien	t 3 DOA Othe		n <i>(Check only one</i> me 5 □ Resider	) ice 6  ☐Other (Speci	fv)
	Attending Phir death. actor: After thi	atlon: T	27. Manner of Death  1 VNatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye	28b, Time of	28c. Injun Work		28d. Describe hov		
Division	tai or Atte s aftar da ai Diracto ad in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - building, etc. (S	At home, farm, stre pecify)	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or Run State)	al Route Number,
	To the Hospital or Atti within 24 hours after de To the Funeral Direct completely filled in by the	edica! (	29a. Certifier 1 Certifying Physical (Check only one) 2 Medical Examin	ician: To the best of m er: On the basis of exa and manner stated.	ımination and/or inv	occurred at the tim restigation, in my or	ne, date and place, pinion, death occurr	and due to the car ed at the time, dat	use(s) and manner as s e and place, and due t	stated. o the cause(s)
	To the within 2 To the complet	M	29b. Signature and title of certifier			29c. License			d. Date signed (Month,	
•			> 5 Chan	Eme			638		MAREH 1-	2005
	9		30. Name and address of person who co	M.J	July hu	Print)	Fredt	en Merge	do d =15	32
	Sta Registr		31. Date filed (Month, Day, Year) MAR 2 4 2005	32. Registrar's	Signature					

			For	State of M						•	ne Legible.	10070
			For State Registrar			Cei	rtificate o	f Death	1	Reg	No.	10073
	Physicia	an	1. Decedent's Name (First, Middle	e, Last)					2.	Date of Death Month	Day Year	3. Time of Death
	/Medic	al	Hazel Amanda		)		4b. City, Town	or Location		March 9	2005 4c. County of Dea	0420 M
	Examin	er	4a. Facility Name (If not institution	ial Hospit				ston	or Death		Talbot	
	Funeral		5. Social Security Number	6. Sex 7. A		ast birthday)	If Under 1 Yea	r If Under	r 24 Hrs. 8.	Date of Birth (Month, Day, Ye		thplace (State or Foreign ountry)
	Director		220-03-5743	1□M 2 <b>X</b> F	82	Yrs.	Months Day	s Hours	Min.	July 12,	1922 Ma	aryland
_	and		Usuel Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	ocation					10d. Inside City Limits
	Maryl -f sho	tor	MD Doro	chester			Churc	h Cree	ek			1 ☐ Yes 2 No
J	within 72 hours after death with the Maryland ene. then "neturel", or items 23e or 28a-f show the Marical Exstition must be notified at	Director	10e. Street and Number				10f. Zip Code			10g.	Citizen of What C	ountry?
$\downarrow$	23e o	al D	2839 Lakesvi	lle Crapo Ro	ad				1622		USA	
<i>、</i>	tems	Funeral	11. Marital Status	12. Was Decedent Armed Forces	?	S. 13.	Was Decedent of If Yes, specify Cu	Hispanic Or Iban, Mexica	rigin? (Specif in, Puerto Ric	y Yes or No- an, etc.)	14. Race - Am Black, Whi	
36	rs afte	oy F	1 ☐ Never Married 2 ☐ Marr 3 ☑ Widowed 4 ☐ Divorced	If Yes Give "			1□Yes 2🕱N	o Specify	<i>t</i> :		Specify: V	white
9	2 hou	Completed by	15. Deceden	t's Education		16a. Dece	dent's Usual Occ	upation	-1 -1	166	o. Kind of Business	/Industry
215	thin 7 en "n	nple	(Specify only higher Elementary/Secondary (0-12)	College (1-4or	5+)	life.	kind of work don DO NOT use reti		st of working			
2	led wi		7	(			line w		anda Nama //	First, Middle, Mai	electi	conics
Maryland 21215-0036	ntal H ed otl	Be	17. Father's Name (First, Middle, Enos W. Fitzh	•						Insley	· ·	
7	should nd Me mark imetic	은	19a. Informant's Name/Relations			19b. Maili	ng Address (Stre	-			ity or Town, State,	Zip Code)
	alth ar 27 is 37 is		Wayne Foxwell	L	son	2841	Lakesvi	lle Cr	capo Ro	l., Chur	ch Creek	MD 21622
ore,	of Her of Her fitem r othe		20a. Method of Disposition  1 Burial 2 □ Cremation	3 □Removal from State			osition (Name of matory or other p		Date		Location - City or	
Ĕ	Pag ment tent: I		° 4 Donation 5 Other (S	pecify)	Dor						ambridge,	
Baltimore,	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or items 23e or 28a-f show any injury or other treumetic event. It a Modical Examination that be notified at once.		21. Signature of Funeral Service	Licensee			2. Name and Add			mas run idge, M	eral Home D 21613	P.A.
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cause	ed the death						and the same of th	Approximate
	Dhysisian		Immediate Cause (Final	only one cause on each	line.	unci	erdial	ula	chu	n		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	aDue to (or as	s a consequ	uence of):	erdial tera d	U.				70.3
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	be sit	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	s a conseq	uence of):	,					11.
	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as	s a conseq	uence of):						
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89		ed										
Вох	The law requires that the death certifica ate has been signed by the attending ph bage 2 should be detached for use as th	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			∃Ectopic pregnar	ncy			23d. Date of de Month	livery Day Year
Ш	the at	/sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□Unknown	at time of d	eath 5[	Other (specify)			<del></del>	Worth	Day 16a
P.O.	that the sed by detacl		Part II. Other significant condition	ons contributing to death	but not res	ulting in the u	nderlying cause	given in Part	l.	23e. Did tobac	co use contribute t	o the cause of death?
ds,	uires tha signed td be det	d by	Possible.	Sepsi						1 ☐ Yes	2 □ No 3 ☐ P	robably 4 Unknown
Vital Records,	w require s been si should l	Completed	diabeter	,\						24a. Was an		utopsy findings available
Re	The taw ate has page 2 :	шо	early ser	lig ,						autopsy performed 1 Yes 2 1	1?_  death?	completion of cause of s 2 □ No
ita	(0	Bec	25. Was case referred to medica examiner?						e of Death (0	Check only one)		
of \	hys this al dii	P.	1 Yes 2 No	Hospital: 1 Inpat			IL 3 DOA			5 Residence	e 6 Other (Spe	ecify)
no	ding After fune	tlon	1 ☑Natural 5 ☐ Pendir	ng (Month, D	ay Year)	28b. Time o Injury	V	lork? ⊡Yes 2.[		1. Describe now i	injury occurred	
Division	f or Attending after death. Director: After I in by the fune	ifica	3 ☐ Suicide 6 ☐ Could	not be 28e. Place of Ir	njury · At ho	ome, farm, st	reet, factory, offic	9	281			ural Route Number,
Ö	o ir	Certification:	4 Homicide	building, e	etc. (Specif	Y)				City or Town, S	rare)	
	To the Hospitel or Attent within 24 hours after deati To the Funerel Director: completely filled in by the	edical (	29a. Certifier 1 Certifyir (Check only one)	ng Physicien: To the bes Exeminer: On the basis and manner s	of examina	wledge, deat tion and/or in	h occurred at the vestigation, in m	time, date a opinion, de	and place, and eath occurred	d due to the caus at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
1	To the within To the comp	ž	29b. Signature and title of certifie	Smide				nse number	1	29d.	Date signed (Mon	
7			30. Name and address of person	<u> </u>	death /Iton	1 23a) (Tuno		(39)			1 ' '	
			30. Name and address of person  David H. Sn					., Sui	te 5,	Easton,	MD 2160	1
	Sta		31. Date filed (Month. Day, Year,				Conto	-				
	Registi	rar	MAK	1 1 2005	36450	B.	6000					

Hazel Foxwell

			For State Registrar	State of Maryla		artment of H			giene 0 0	5 10080
			Decedent's Name (First, Middle, Last	st)				2. Date of De	ath	3. Time of Death
	Physicia		Mary Toide	elle Flemino	7			March	12. 20	9:15 P M
	/Medic Examin		4a. Facility Name (If not institution, give		J	4b. City, Town, or	Location of Dea		4c. County	
	CXamiii	٠ <b>،</b>	29204 Woodridge			East	on		Tal	bot
	Funeral		5. Social Security Number 6. S	ex 7. Age (In yr	s. last birthday,	If Under 1 Year			th	Birthplace (State or Foreign Country)
	Director	1	216-18-2219	□ M 25 <b>x</b> F	91 Yrs.	Months Days	Hours Mil	October	13, 1913	Maryland
7	D		Usual Residence of Decedent							40d Inside City Limite
	rylan		10a. State 10b. County	10c. 0	City, Town or L	ocation				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	e Ma	cto	Maryland Talbot	-	East					
	ith th	Directo	10e. Street and Number			10f. Zip Code			10g. Citizen of W	Mat Country? States of .
	23a		29204 Woodridge I	rive		21601				America
	r dez	Funerai	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? ( an, Mexican, Pue	Specify Yes or No orto Rican, etc.)	- 14. Hace Blac	e - American Indian, k, White, etc.
õ	or It	ΥFL	1 Never Married 2 Married	1 ☐ Yes 2 ☐ No If Yes, Give		1 ☐ Yes 2 ☑ No	Specify:		Specify	:
5-0036	hours after death with the Maryland turat; or Itema 23a or 28a-f show Exstringt must be notified	d by	3 Widowed 4 □ Divorced	Year or Dates:	10. 5				16b. Kind of Bu	Caucasian
က်	72	Completed	15. Decedent's Ed (Specify only highest gra	ducation de completed)	(Give	dent's Usual Occup <i>kind of work d</i> one of <i>DO NOT</i> use retired	during most of w	orking	TOD. KING OF BU	siness/moustry
7	withir	du	Elementary/Secondary (0-12)	College (1-4or 5+)			,		Ц	ome
N	filed within Hygiene. Ither than "	ပိ	17. Father's Name (First, Middle, Last,	)	H	omemaker	18. Mother's Na	ame (First, Middle	, Maiden Sumam	
au	e d fa	Be						rah Anne		
Maryland	should ind Men i marke umatic	우	19a, Informant's Name/Relationship (	ernard Allen	19b. Mail	ing Address (Street				State, Zip Code)
<u>s</u>	d 2 th a tra			Daughter		4 Woodrid				
	s 1 and / Health item 27 other to		Jean Cooper  20a. Method of Disposition			osition (Name of smatory or other place		Date		City or Town, State
وَ	0 0		1 ☑ Burial 2 ☐ Cremation 3 ☐	JMemovai from State				7/2005	u: llabor	ro, Maryland
altımore,	permit. Pag Department Important: h any injury o		* 4 ☐ Donation 5 ☐ Other (Specifical Service Lice)			nt Cemete: 2. Name and Addres	+	7/2005	пттг	lo, maryland
Ba	Depa impo any i		21. Signature of Furnish Solvice Lice	Moore -	1 .	Moore Fun	eral Hor	ne, P.A.		
			23a. Part1. Enter the disease, or com	plications that squeed the de	ath Do not or	12 South	Second S	Street, I	Denton, I	Maryland 21629
			shock, or heart failure. List only	one cause on each line.			19, 55511 45 54.4.	ao or roopmanory o		Interval Between Onset and Death
	nysician	6 B	Immediate Cause (Final disease or condition	a. Pre	unon	12				1 M 2176
	/Medical Examiner		resulting in death)	Due to (or as a cons	sequence of):	- 01		- /.,	.0	297000
	LXummiçi	_	Sequentially list conditions,	b. Due to (or as a cons	BY YOCI	102 101	MONTAL	1 4/16:	>/ <	27/27/
	be sit	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a corrs	equence on.	rtern	21100	re		2070201
	and and I-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or as a cons						
8760,	certificate be executed iding physician and use as the burial-transit	Ë		200 10 (41 20 20 11						
	ate hys	dicai	•	d						
9 X	eath certific attending p	Physician/Med	IF FEMALE:	23c. If yes, outcome of pre-	gnancy				23d Dat	e of delivery
Box	atten for us	lan	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ F 4 ☐ Pregnant at time of	etal death 3	☐Ectopic pregnancy ☐ Other (specify)	1		Mo	
o.	at the de by the a tached	ysic	.1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	or double	_ oo. (opoolity) _				
1	The law requires that the death ate has been signed by the atter bage 2 should be detached for u		Part II. Other significant conditions	contributing to death but not	resulting in the	underlying cause grv	en in Part I.	23e. Did	tobacco use conti	ribute to the cause of death?
ds,	signed by det	d by						1 🗆	Yes 2□No	3 Probably 4 Unknown
Ö	w require been sig should b	Completed						24a. Wa:	s an 24h \	Were autopsy findings available
ě	has has	mpi						auto	posv r	prior to completion of cause of death?
8										Yes 2 No
Ž	or Attending Physicien: The law after death. Director: After this certificate has I in by the funeral director, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:		Oth		eath (Check only		(0)(-)
ō	Phys this ral di	To T	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injury	28b. Time				idence 6 Oth	
U	ding I	tion	1 Natural 5 ☐ Pending	(Month, Day Year		Wor	rk?  Yes 2∐No			
S	or Attendate death Director:	ica	3 ☐ Suicide 6 ☐ Could not b	OB Disease Alaine	t home, farm, s			28f. Location	(Street and Numb	er or Rural Route Number,
Division of Vital Records,	after Dire	Certification:	4 Homicide determined	building, etc. (Spe				City or To	iwn, State)	
	pita ours verai filled		29a. Certifier 1 Certifying P	hysician: To the best of my	knowledge, dea	th occurred at the tir	me, date and pla	ice, and due to the	cause(s) and ma	inner as stated.
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edicai	(Check only 2 Medical Exa	miner: On the basis of exam and manner stated.	ination and/or	nvestigation, in my o	opinion, death oc	curred at the time	, date and place,	and due to the cause(s)
	of the	₩ Z	29b. Signature and title of certifier	110		29c. Licens				d (Month, Day, Year)
	⊢ s ⊢ ō		V alue	MD		000	> 5/137	_	7-1	7.05
			30. Name and address of person who	completed cause of death (	Item 23a) (Type	e, Print)				
			Jorge Abrego, M.				. Marvla	and 21629	9	
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Si	gnature		,			
	Regist		MAR 1 4 2005	1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1	A DOM	اللهرا				

	1	For State Registrar	• •	aryland / Depa	artment of Health rtificate of Death	and Mental Hy	_
Physicia /Medica Examine	n al	Decedent's Name (First, Middle Alice     Alice     A. Facility Name (If not institution,	D.	Gorche	4b. City, Town, or Location	2. Date of De Month	Day Year 7: 29 AM  4c. County of Death
Funeral Director		39 New Hamps 5. Social Security Number 213-24-6371	6. Sex 7. Ag	ge (In yrs. last birthday) 78 Yrs.	Cumberland If Under 1 Year If Under Months Days Hours	or 24 Hrs. 8. Date of Bir (Month, Da Jan 26	Allegany  9. Birthplace (State or Foreign Country) 1927 MD
pu »		Usual Residence of Decedent 10a. State 10b. County MD Allec		10c. City, Town or Lo	perland		10d. Inside City Limits 1, ✓ Yes 2 ◯ No
uth with the Marylan 23a or 286-f show	al Direct	10e. Street and Number 39 New Hampsl			10f. Zip Code 2150	2	10g. Citizen of What Country?
Baltimore, Maryland 21215-0036 permit. Pages and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23a or 28e-1 show any injury or other traumatic event, the Medical Examinar mather multiple at once.	Completed by Funeral Director	11. Marital Status  1 Never Married 2 Marri 3 Widowed 4 Divorced	12. Was Decedent Armed Forces' ed 1 Tyes 2 Tild Yes, Give X Year or Dates:	No	Was Decedent of Hispanic C If Yes, specify Cuban, Mexic 1 ☐ Yes 2 No Specify		14. Race - American Indian, Black, White, etc. Specify: white
Baltimore, Maryland 21215-0036 sernit. Pages 1 and 2 should be filed within 72 hours alt papartment of Health and Mental Hygiene. mportent: If item 27 is marked other than "natural", or nny injury or other traumatic event, the Medical Exprin	ompleted	15. Decedent (Specify only highes Elementary/Secondary (0-12)	's Education t grade completed)  College (1-4or	16a. Dece (Give life. 5+)	dent's Usual Occupation kind of work done during mo DO NOT use retired)	ost of working	16b. Kind of Business/Industry  Kelly Springfield Tire
yland 2 ould be filed Mental Hyg harked other natic event,	To Be C	17. Father's Name (First, Middle, Amos A. Mon	nette		Lu	her's Name (First, Middle cy Mary Web	, Maiden Sumame) Per Monnette
e, Mar 1 and 2 sh 1 ealth and 1 ealth and 1 her traum	1	19a. Informant's Name/Relationsl Bruce Gorche  20a. Method of Disposition	nip ( <i>Type, Print</i> ) husb	and 39 N	New Hampshire	e Ave. Cumb	er, City or Town, State, Zip Code) Derland MD 21502  20c. Location - City or Town, State
ti Pages riment of H		1 ☑ Burial 2 ☐ Cremation  1 ☑ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (S)  21. Signature of Funeral Service	oecify)	St. Mary's C	position (Name of matory or other place)  Cemetery  2. Name and Address of Face  Scarpelli Fund	3/23/2005	·
Physician /Medical Examiner	Examiner	23a 1.1. Iter the disease, or shock, if heart failure. List Immediate Lause (Finat disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or a:	The death. Do not entine.  A L S a consequence of):  S a consequence of):  S a consequence of):	ter the mode of dying, such a	Avenue: Cumbe as cardiac or respiratory a	rland, MD 21502 rrest, Approximate Interval Between Onset and Death  M. M. O. M.
vision of Vital Records, P.O. Box 68760 and administrate be extending Physicien: The law requires that the death certificate be ector: After this certificate has been signed by the attending physician by the funeral director, page 2 should be detached for use as the burit	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death 3	□Ectopic pregnancy □ Other (specify)	Caul	23d. Date of delivery Month Day Year
ords, P.(	ted by Ph	Part II. Other significant condition	ons contributing to death	but not resulting in the u	Inderlying cause given in Par		tobacco use contribute to the cause of death?  Yes 2 No 3 Probably 4 Unknown
Vital Reci	a)	RELEASED  25. Was case referred to medica	Dr.	51456	26. Pla	24a. Was auto perfect the perfect that t	psy prior to completion of cause of death?  2 No 1 Yes 2 No
Division of Vital Records,  To the Hospital or Attending Physicien: The law requirest within 24 hours after death. To the Funeral Director: After this certificate has been signs completely filled in by the funeral director, page 2 should be to	ToB	examiner?  iX Yes 2 No  27. Manner of Death  I Deffural 5 Pendir  Accident investi	28a. Date of Ing (Month, D	ient 2 ER/Outpatie		28d. Describe	idence 6 Other (Specify) - how injury occurred
Division ital or Attending after death or all Director: A led in by the fi	Certification;	3 Suicide 6 Could determ	28e. Place of li building, e	njury - At home, farm, st etc. <i>(Specify)</i>		City or To	Street and Number or Rural Route Number, wn, State)
Division To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier 1 eritfyir (Check only one) 2 Medical 29b. Signature and title of certifier	Examiner: On the basis and manner s	of examination and/or in	th occurred at the time, date evestigation, in my opinion, d 29c. License number	leath occurred at the time,	cause(s) and manner as stated. date and place, and due to the cause(s)  29d. Date signed (Month, Day, Year)
6		30. Name and address of person	who completed cause of	death (lippy 23a) (Type	Print) 9/7 50%	55/35 Jan De Car	Moderal uno
Stat Registra		31. Date filed (Month, Day, Year)	67.	trar's Signature	and a		

			. For	State of N			artmer	nt of H	ealth ar		-		OOF	100	000
			State Registrer			Cei	tificat	te of L	Death		- 15	Reg. No.	CUU	100	187
	Physicia	an	Decedent's Name (First, Middle, Las	t)						2	. Date of De Month	Day	Yea	1	of Death
	/Medic		Clayton Irvin Grul					_			larch		2005 County of De	5:15	P "-
	Examin		4a. Facility Name (If not institution, give					_	Location of I	Death					
			Northampton Manor 5. Social Security Number 6. Se	Nursing	Home	last birthday)		deric	K If Under 24	4 Hrs.   g	. Date of Bir		ederic 9. E	K. Birthplace (State Country)	or Foreign
	Funeral Director			X M 2□F	75	Yrs.	Months			Min.	Date of Bin (Month, Date 21	y, Year)	29 Ms	Country) ary1and_	
			Usual Residence of Decedent							1.4	000.21	, 1			
	yland		10a. State 10b. County		10c. City	y, Town or Lo	cation							10d. Inside (	
	a-fs	ctor	Maryland Frederic	k	Fred	erick									s 2 No
	be filed within 72 hours after death with the Maryland at Hygiene. A let Hygiene death with the Maulital Examiner number natified at event, the Maulital Examiner number natified at	Directo	10e. Street and Number				10f. Zi	p Code				10g. Citiz	en of What	Country?	
	ath w		200 East 16th Str				217			0.10		USA	A Dage A	merican Indian.	
	tems	Funerai	11. Marital Status	12. Was Decede Armed Force	s?	.S.   13. \	Was Dece If Yes, spe	edent of Hi ecify Cuba	ispanic Origii n, Mexican, I	n? (Spec Puerto Ri	ican, etc.)	0-	Black, W		
20	s afte	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 If Yes, Give Year or Date:	_		1 🗌 Yes	2 🔀 No	Specify:				Specify: נגדו	hite	
3-003p	within 72 hours after ene. then "naturel", or Ite te Medical Examitre		15. Decedent's Ed			16a. Dece	dent's Usi	ual Occupa	ation			16b. Kir	nd of Busine		
Ò	n "na	plet	(Specify only highest gra	de completed) College (1-4d	or 5 . \	(Give	kind of w DO NOT	ork done d use retired	during most o	of working	7				
7	r tha	Completed	Elementary/Secondary (0-12)  5	College (1-40	JI 3+)	Labore	r					Matt	ress M	lanufact	uring
2	e filed Il Hygie other	a	17. Father's Name (First, Middle, Last)						18. Mother:	's Name (	First, Middle	, Maiden	Sumame)		
land		O B	Norman A. Grubb						Vada 1	Maw	Cooper	:			
Mary	s 1 and 2 should it Health and Men itam 27 is marka other traumatic	. 0	19a. Informant's Name/Relationship (	Type, Print)		19b. Maili	ng Addres	COUT	and Number	or Rural	Route Numb	oer, City or	Town, State	e, <i>Zip Cod</i> e)	
	and sealth in 27		Mia Brust, Guardi	an	20%	1440	Tane	y Ave	nty De	Fred	erick.	MD	21702	or Town, State	
o E	Pages 1 and the source of the		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	Removal from Sta	0	Place of Dispo cemetery, crea	matory or	other plac							3
Baitimore,	permit. Pages Department of Important: If it any injury or o		`4 ☐ Donation 5 ☐ Other (Specify	y)	Bro					-				, Maryl	
ลูก ต	Depar Depar Impor any ir		21. Signature of Funeral Service Licer	2	MO				ss of Facility	1001	-			Funeral	
	452 * 4		23a Part Enterthe disease or com	Dications that cau									rick,	Mary1an Approxim	ate
			23a. Part Enter the disease, or com shock or heart failure. List only Immediate Cause (Final	one cause on each	h line.	20.00	1.11	س. بر سر	7 A.	21	TRI			Interval B Onset and	
	Physician /Medical		disease or condition resulting in death)		as a conseq	ASTRI	INIC	ES1	11/1/40	00	1500			da	45
	Examiner			Due to (or	as a conseq	luence on.									-
		er	Sequentially list conditions,	b. Due to (or	as a consec	uence of):									
V	uted d ansit	Examiner	cause. Enter Undertying Cause (Disease or injury that initiated events	c											
o Î	be executed sician and burial-transit		resulting in death) Last	Due to (or	as a conseq	quence of):									
1/60	# × 9	icai		d		_		_						-	
68	eath certificat attending phy I for use as the	Med	IF FEMALE:						-						
ROX	ath ce ttend	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth	n 2 🗆 Feta	aldeath 3[		pregnancy	,			2	23d. Date of Month	delivery Day	Year
0	at the dea by the a stached fo	sici	1 Yes 2 No	4□Pregnan 9□Unknow		death 5	Other (	specify)							
<u> </u>	The law requires that the death certifica ste has been signed by the attending ph page 2 should be detached for use as it	Completed by Physician/Med	Part II. Other significant conditions of	contributing to deaf	th but not res	sulting in the u	underlying	cause giv	en in Part I.		23e. Did	tobacco u	ise contribute	e to the cause o	f death?
Records,	w requires that been signed E should be deta	d by	CORONARY A								1 🗆	Yes 2	3 □	Probably 4 [	Unknown
ŏ	v requ been shoul	ete	DIABETES								24a. Wa	s an	24b. Were	autopsy finding	s available
He E	: The law cate has i	mp	VINDELES	111000	, , , , ,						per	opsy formed?	death		cause of
Vital		e Co	25. Was case referred to medical						26 Place	of Death	1 Yes (Check only	2 No	101	165 2 140	
	ysiclan: is certific director,	To B	examiner?	Hospital: 1 Inp	patient 2	ER/Outpatie	nt 3∏ [	Oth	ier: 4 Nur				6 Other (S	Specify)	
O	g Phys er this eral di		27. Manner of Death	28a. Date of		28b. Time o		28c. Injur Wor	v at		8d. Describe				
0	ottending I death. ctor: After y the funer	atio	2 Accident 5 Pending investigation	n	ouy roury	iii,a.y	М		Yes 2□N						
Division of	er de er de recto	Certification:	3 Suicide 6 Could not be determined	280. Place of	f Injury - At h	nome, farm, st	treet, facto	ory, office		2		(Street an own, State		r Rural Route Ni	ımber, 
	ital o irs aft rel Di														
	To the Hospital or Attending Physician: within 24 hours after death. To the Funarel Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier Certifying Pl (Check only 2 Medical Execution)	nysicien: To the b miner: On the bas and manne	is of examina	owledge, dea ation and/or in	th occurre nvestigation	ed at the tir	me, date and pinion, death	d place, a h occurre	d at the time	e cause(s) e, date and	and manner place, and	due to the cause	a(s)
	To the within 2 To the Complet	Me	29b. Signature and title of certifier	3			2	9c. Licens			_	29d. Da	te signed (M	lonth, Day, Year,	)
	⊢ s ⊢ ō			-V	wim	<b>(2)</b>		D	471	16	1	03	-17	-05	
	1		30. Name and address of person who	HA	MD	6	Print)	9TH	AUE.,	BR	UNSI	NICK	MD	21716	,
	St Regist	ate rar	31. Date filed (Month, Day, Year)  MAR 2. 4. 2005	32. Rec	gistrar's Sign	ature	2	*	-/						

Physician Medical Examiner  Physician Medical Examiner  The Company of the Compan				1 = For AMEND#3&4bperf	103/21/05,	Maryland	I / Depa	artment	t of H	ealth a	and Mo	ental Hy	giene	2005	10083
VIRCINIA   R. CERHARDT   Register of the continuous parameter and number   Register of the con						/21/00,D'W	ייעטטייוניי	- Interest		-			ath		3. Time of Death
## February Services of December   Montgomery   Montgomer				VIRGINIA	R.	GERHA	RDT						4 Da	y 2005	Hyl
Second Second Number   Second Second Number   Second Second Number   Second Second Number   Second	}							4b. City, 1	Town, or	Location of					
Symposition				Manor Care				Une.	y Ch <del>thes</del>	ese <del>da-</del>			Mo	ntgome	ry
Unable Relations of December   Texts Alley   Lines		Funeral		Social Security Number 6.			st birthday)					8. Date of Bird	h	O Ri	tholaco (Stato or Foreign
The control of the		Director			1 ∐ M 2Ã  F	102	Yrs.	MONINS	Days	Hours	IVIIII.	Sept.	20,	1902 Во	yd's, MD
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The state of the s		with Sa or			.a #115			101. Zip		1 6			iog. Ci		,
The state of the s		reath ms 20	era		12. Was Dece	edent Ever in U.S.	. 13.1	Was Decede			nin? (Spec	ify Yes or No			
The state of the s	(0	r iter	Fu		Armed Fo	rces?	.   10.	f Yes, speci	fy Cubar	n, Mexican	, Puerto R	lican, etc.)		Black, Whi	te, etc.
The state of the s	8	ours a	þ	3 XWidowed 4 ☐ Divorced	If Yes, Giv	/8		I□Yes 2	X No	Specify:				Specify: Wh	nite
The state of the s	2-0	72 ho	ted				16a. Deced	lent's Usual	Occupa	tion					
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Physician Medical Examiner  The proposed of the properties of the	pu	be fill d oth	Be		•								Maiden	Sumame)	
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Physician Medical Examiner  The proposed of the properties of the	Mai	d2st thanc then treun					19b. Mailin	g Address	(Street a. 1 Δ τ	nd Numbe #410	ror Rurai	Route Numbe	r, City o	r Town, State,	Zip Code)
Physician Medical Examiner  The proposed of the properties of the	Ġ,	1 an Heali Iem 2 Uher													Town State
Physician Medical Examiner  The proposed of the properties of the	OE.	ages ant of				State cen	netery, cren	natory or oth	her place	)   M	arch 200	7 <b>,</b>			
Physician Medical Examiner  The proposed of the properties of the	alt:	mit. F bartme sorter / injur		1 9	-	Tair				s of Eacility					
Physician Medical Examiner  Por Part I in the first disease, or compleciations that caused the doaln. Do not enter the mode of dying, such as cardiac or respiratory arrest; inclinate determinant in the past 12 months?  Part I of the past 12 months?  Part II of the past 12 months?  Part III of the significant conditions of the past 12 months?  Part III of the past 12 months?  Part III of the significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part III of the significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part III of the significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part III of the significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part III of the significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part III of the significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part III of the significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part III of the significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part III of the significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part III of the significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part III of the significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part III of the significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part III of the significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part III of the significant conditions contributing to death but not resulting in the underlyin	Ö	Per Imp		herry A	SILI					Was	2 Wis hingt	consin con, D.	C.Av	eooo <sup>N.W</sup>	•
Privation   Privat	г			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that c	aused the death. ach line.	Do not ente	er the mode	of dying	, such as	cardiac or	respiratory ar	rest,		
Due to (or as a consequence of):  Sepsis  Due to (or as a consequence of):  Sepsis  Due to (or as a consequence of):  Sepsis  Due to (or as a consequence of):  Congestive Heart Failure  Due to (or as a consequence of):  Congestive Heart Failure  Due to (or as a consequence of):  Congestive Heart Failure  Due to (or as a consequence of):  Hypertension  Franchise of the death of the congestion of the conges		Physician			Pneun	nonia									Onset and Death
Separation of the part of the				resulting in death)	Due to (	or as a conseque	nce of):					1.4			
The content of the			_	Sequentially list conditions.	0.										
FEMALE:   23b. Was dozedent pregnant in the past 12 months?   1   1   1   1   1   1   1   1   1		ed sit	ine	if any, leading to immediate			51 S								
FEMALE:   23b. Was dozedent pregnant in the past 12 months?   1   1   1   1   1   1   1   1   1		and and I-tran	хап	that initiated events	U.			allur	e						
FEMALE:   23b. Was dozedent pregnant in the past 12 months?   1   1   1   1   1   1   1   1   1	9	be e sician buria	a E				1100 01).								
Spoop   Spoo	687	ficate p phys	(a)		_ d										
Spoop   Spoo	X	nding use a	N											23d Date of de	livery
25. Was case referred to medical sexaminer?  1	m	death e atte	Cla	in the past 12 months?	4☐Pregn	ant at time of deat									
25. Was case referred to medical sexaminer?  1	Ö.	by th	hys		9∐ Unkno	wn									
25. Was case referred to medical sexaminer?  1	_	gned gned se de	by P	Part II. Other significant conditions	contributing to de	eath but not resulti	ing in the ur	derlying car	use giver	n in Part I.		23e. Did to	bacco L	se contribute to	the cause of death?
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25. Was case referred to medical sexaminer?  1	ec C	law r as be 2 sh	ple											24b. Were at	itopsy findings available
Secondary   Seco		The ate h page	Com									perfor	med? 2 XI No	] death?	
The state of the s	/ita	clen: ertific								26. Place	of Death (				
1	_	hysi this o	၉	1 ☐ Yes 2 🔀 No	101		NOutpatient	3□ DOA	Other	· 4X Nur	sing Home	9 5 ☐ Resid	ence (	6 □Other (Spe	cify)
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check only one)  29b. Signature and title of certifier  29b. Signature and title of certifier  29c. License number  D20274  March 7, 2005  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Kirti Vohra, M.D. 7710 Bradley Blvd. Bethesda, MD 20817	U U	After unera	ino ino	1 X Natural 5 ☐ Pending	(Monti	of Injury 28 h, Day Year)	8b. Time of Injury		c. Injury : Work?	at ?	28				
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check only one)  29b. Signature and title of certifier  29b. Signature and title of certifier  29c. License number  D20274  March 7, 2005  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Kirti Vohra, M.D. 7710 Bradley Blvd. Bethesda, MD 20817	Sic	ten eat or:	cat							es 2□N					
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check only one)  29b. Signature and title of certifier  29b. Signature and title of certifier  29c. License number  D20274  March 7, 2005  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Kirti Vohra, M.D. 7710 Bradley Blvd. Bethesda, MD 20817	$\leq$	or Ai after Direc in by	ertif	determine.	288. Place	of Injury - At home ig, etc. <i>(Specify)</i>	e, farm, stre	et, factory,	office		28	f. Location (S City or Tow	treet an n, State	d Number or Au )	ıral Route Number,
29b. Signature and titig of certifier  D20274  D20274  March 7, 2005  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Kirti Vohra, M.D. 7710 Bradley Blvd. Bethesda, MD 20817	_	spitel		29a. Certifier 11 Certifying P	hvsician: To the	hast of my knowle	adre death	occurred at	the time	data and	Lolaco, an	d due to the e	21150/51	and manner as	and and
29b. Signature and titig of certifier  D20274  D20274  March 7, 2005  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Kirti Vohra, M.D. 7710 Bradley Blvd. Bethesda, MD 20817		he Ho n 24 h he Fui	edlo	(CINCK CIT) Z MEGICAL EXE	miner: On the pa	isis of examination	n and/or inv	estigation, in	n my opi	nion, death	occurred	at the time, d	ate and	place, and due	to the cause(s)
D20274 March 7, 2005  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Kirti Vohra, M.D. 7710 Bradley Blvd. Bethesda, MD 20817		To t To tl comp	Σ	29b. Signature and title of centifier	1 las	10	M.	7)				2	9d. Dat	e signed (Monta	h, Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Kirti Vohra, M.D. 7710 Bradley Blvd. Bethesda, MD 20817				Kul	VON		1 = (, )	]	D2 <b>0</b> 2	74			Mar	ch 7, 2	2005
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State 31. Date filed (Month, Day, Year) 32. Hegistrar's Signature									esda	, MD	2081	7			
THE STATE OF LUCY I THE STATE OF THE STATE O		Stat Registra			005	agustrar's Signatur	do	uli							

( 4/	_	1 - For State Registrar				artment of I rtificate of			Reg. N	2000	1008
Physic	ian	Decedent's Name (First, Middle, L     ROBERT RUSSEL	.ast) L GOODMA	l NI				2. Date of I Month MARCH	Death Da		3. Time of Death
/Medi Exami		4a. Facility Name (If not institution, ga				4b. City, Town, o	or Location of Deat			2005 c. County of Dea	9:10AM
		6807 HALLOWELL F					LOCK			DORCHE	STER
uneral irector		5. Social Security Number 6. 103–36–0793	Sex M 2□F	. Age (In yrs. <b>59</b>	last birthday) Yrs.	Months Days	Hours Min.	8. Date of E (Month, I	Birth Day, Ye <i>ar)</i> <b>0 19</b>	9. Bir Co NEW	thplace (State or Fore ountry) YORK
M		Usual Residence of Decedent  10a. State 10b. County		10c, Cit	ity, Town or Lo	ocation					10d. Inside City Lim
Importent: it tem 2/ is marked other trien "natural", of fems 23e or 28a-f show my injury or other traumatic event, the Medical Examiner must be notified at once.	tor	MD DORCH	ESTER		HURLO						1 Tyes 2
De not	Funeral Director	10e. Street and Number				10f. Zip Code			10g. Ci	itizen of What Co	ountry?
	eral	6807 HALLOWELL  11. Marital Status	ROAD  12. Was Decede	ent Ever in III	19 12		21643	posify Voc or B	10	USA.	des ladi-
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	Com	Elementary/Secondary (0-12)	College (1-4	lor 5+)	DRAJ	FTSMAN			BUII	LDING MA	TERIAL
	Be	17. Father's Name (First, Middle, Las ROBERT S. GOODM					18. Mother's Nan		le, Maiden	n Sumame)	
NI WATT	T <sub>0</sub>	19a. Informant's Name/Relationship			19b. Maili	ng Address (Street		HILTZ	ber. City o	or Town. State.	Zip Code)
5		JOAN GOODMAN /	WIFE			HALLOWEL					,
		20a. Method of Disposition  1	☐Removal from Sta	ate C	cemetery, crei	sition (Name of matory or other plac		Date		ocation - City or	
		<ul> <li>4 □ Donation 5 □ Other (Spec.</li> <li>21. Signature of Funeral Service Lice</li> </ul>		MD	ALTEKA	N CEMETE	KI 3-10	6-2005	HUKI	LOCK, MI	)
음음			311200		22	2. Name and Addre	ss of Facility				
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Stete Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** MARCH 13 2005 3:30PM JOYCE C. GLOVER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner TALBOT 30125 RABBIT HILL ROAD EASTON 8. Date of Birth (Month, Day, Year) OCT 22 1936 If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country)
 MARYLAND 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 □ M 2√□ F 68 Yrs 220-32-9697 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d Inside City Limits 10a State 10b. County ortant: If item 27 is marked other than "natural", or items 23a or 28a-1 show injury or other traumatic event. The Machinal Examiniter is used for radiillad all 1 Yes 2 No Director TALBOT EASTON 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 30125 RABBIT HILL RD IISA 14. Race - American Indian, Black, White, etc. 21601 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 COLLEGE 0 REGISTRAR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be SAMUEL WINFIELD ROE NATALENE LLOYD 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any injury or other trau JOHN A. GLOVER/HUSBAND 30125 RABBIT HILL RD., EASTON, MD 21601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) WOODLAWN MEMORIAL PARK 3-21-2005 EASTON, MARYLAND 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 NOHN R. MERCERON 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause the each line.

Immediate Cause (Final disease or condition Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 PNo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Vas 2 No certificate 1 Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospitat: 1 ☐ Inpatient Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 🐼 No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) title of certifier 29b. Signature a LO' 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 29466 PINTAIL DR., EASTON, MD 21601 DAVID SMITH M.D. Day, Year) 2005 Registrar's Signature 31. Date filed State Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 2005 Joseph Gallagher March 10. 10:15 PM John /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner Solomons, Calvert Solomons Nursing Center 8. Date of Birth (Month, Day, Year) If Under 1 Year Months Days Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Hours Yrs. 185-10-1122 91 Sept. 1, 1913 Pennsylvania Director Usual Residence of Decedent a filed within 72 hours after death with the Maryland at Hygiene. other than "natural", or items 23e or 28e-f show 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State ral", or itama 23a or 28a-f show Examinar must be notified at 1 Yes 2X No Director Maryland St. Mary's Dameron 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20628 U.S.A. 18121 Yoda Lane by Funera Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? XYes 2 🗆 No 1 □ Never Married 2 □ Married 1 Yes XXNo Baltimore, Maryland 21215-0036 Specify: Yes. Give If Yes, Give Year or Dates: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Federal Government 12 Claims Administrator 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be in nent of Health and Mental int: if item 27 is marked o Joseph Aloysius Gallagher Caroline Love Kennedy 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P.O. Box 250, St. Inigoes, Maryland 20684 John Joseph Gallagher / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date parmit. Pages 1
Dapartmant of F
important: if its
any injury or ot
once. West 3/18/2005 ' 4 Donation 5 Other (Specify) Calvary Cemetery Conshohocken, PA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Brinsfield Funeral Home, P.A. P.O. Box 279 Leonardtown, Maryland 20650-0279 100052 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cerebro Vascular de **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events ad by the attending physician and datached for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
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1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown signad by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 ☐ Probably 4 ☐ Unknown Severe 1 Yes 2 00 baan 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes XX No 1 🗌 Yes or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Wursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 X No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Aftar 1 Natural 5 Pending 1 Tes 2 TINo daath. investigation 2 Accident after daath filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 THomicide within 24 hours at To the Funaral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 11-2005 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) irenes trude or MD 20678 HOSP ANWAR MUNSHI M · D . 110 10 Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 1 6 2005 Registrar

				artment of Health and Mertificate of Death	_	ene 005	10087
	Physici	an	Decedent's Name (First, Middle, Last)		2. Date of Death Month		3. Time of Death
	/Medio		Mary Sue Hash		March	16 2005	1415 PM
	Examir	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Dea	ith
	Funeral		24 Mount Rocky Lane 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Colora    If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	Cecil	thnlace (State or Foreign
	Director		206-12-0391 1□ M 21XF 86 Yrs.	Months Days Hours Min.	June 21,	1918 Ten	thplace (State or Foreign ountry) INESSEE
	pur *		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or L	oestice.			
	Aaryla f sho	ō		ocation			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	28a-	Director	Maryland Cecil Colora	10f. Zip Code	100	g. Citizen of What C	
	h with	al Di	24 Mount Rocky Lane	21917		United	,
	ems a	Funeral		Was Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto R	cify Yes or No-	14. Race - Am	erican Indian,
36	s afte		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give	1 ☐ Yes 2 ☒ No Specify:		Black, Whi	
Maryland 21215-0036	filed within 72 hours after death with the Maryland Hygiene. kther then "natural", or Items 23e or 28e-1 show ent, the Medical Examiner must be notified at	Completed by		edent's Usual Occupation	16	8b. Kind of Business	nite
75	hin 72	piet	(Specify only highest grade completed) (Give life.	e kind of work done during most of workin DO NOT use retired)	g	DD. KING OF BUSINESS	vindustry
7	ad wit	Con		memaker	]	In Her Own	n Home
ğ	be fill stat Hy ed oth	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name			
⋛	hould d Mer marke matic	욘	Isaac Gentry  19a. Informant's Name/Relationship (Type, Print)  19b. Maili	Nannie F			-
<u>8</u>	od 2 s lith an 27 is : traus			ing Address <i>(Street and Number or Rural</i> Box 75, Colora, Ma			Zip Code)
ē,	s 1 au of Hea item othe		20a. Method of Disposition 20b. Place of Dispo	osition (Name of Da		c. Location - City or	Town, State
Ĕ	Page nent c ant: # ury or		1 X Burial 2 □ Cremation 3 □ Removal from State  1 A □ Donation 5 □ Other (Specify)  Cemetery	Baptist Church   March   2005		onowingo.	Mary land
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23e or 28a-1 show any injury or other traumatic event, the Madical Examiner must be notified at once.			2. Name and Address of Facility	rale D	Λ	naryrand
	70 E # 9		David S. Kubs 1	2. Name and Address of Facility Licks Home for Funer 03 W. Stockton Stre	eet, Elk	ton, Mary	land 21921
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final			t,	Approximate Interval Between Onset and Death
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8760,	The law requires that the death certificate be executed as been signed by the attending physician and cage 2 should be detached for use as the burial-transit	EX	Due to (or as a consequence of):				
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Box	eath certific attending p	Ž	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	_		23d. Date of del	iverv
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<u>о</u>	that the de ed by the detached	Phys	9 🗆 OUKNOWN				
Š	w requires that been signed should be det	þ	Part II. Other significant conditions contributing to death but not resulting in the u				the cause of death?
Records,	v requ	etec	THERICIOSION, JAPPOINTICONS				
ě	The lav	Completed			24a. Was an autopsy performer	prior to o	topsy findings available completion of cause of
Vital		BeC	25. Was case referred to medical	26. Place of Death		No 1 ☐ Yes	2 No
	Physician; this certific al director,	ToB	examiner? 1 ☐ Yes 2 🕅 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatier	0.0		e 6 □Other (Spec	cify)
ē O	ding Ph h. After th funeral		27. Manner of Death 1. SNatural 5 ☐ Pending (Month, Day Year) Injury		d. Describe how		
<u> </u>	Attendi death. ctor: A y the fu	cati	2 Accident investigation	M 1 Tes 2 No			
Division of	I or At after d Direct I in by	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, str	eet, factory, office 28	f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
	Hospital or Attending Physician: 4 hours after death. Funerel Director: After this certificiely filled in by the funeral director,		29a. Certifier 12 Certifying Physician: To the best of my knowledge, death	n occurred at the time, date and place, an	d due to the caus	se(s) and manner as	stated.
	To the Hospital or Attend within 24 hours after death To the Funerel Director: completely filled in by the	Medical	one) and manner stated.	vestigation, in my opinion, death occurred	at the time, date	and place, and due	to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of Certifler	29c. License number		Date signed (Month	
		-	Maliajan MD	045344	0	3/17/20	05
	6		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print) FOOD ANE, HAVRE DE	00100	/. X = /	
	Sta	e	SURES H DHANTANI, 75 622 S. ONI 31. Date filed (Month, Day, Year)  22. Registrar's Signature	IN AVE TAVKE DE	GKACK	MUZIC	10
	Registra	ar	MAR 2 4 200 Marco 15 April	W,			

			1 - For State Registrar	S	State o	f Marylar		artmer ertificat				lental Hy	giene Reg. No	UUU	And the second	008	8
П	Physici	an	Decedent's Name (First, Middle     Maggio)	, Last)		Hall						2. Date of De Month	Day	y Ye		3. Time of I	Death
	/Medic	al	Mazie			_		1				March				8:45	рм
	Examin	er	4a. Facility Name (If not institution							Location of			4c.	. County of D	eath		
	·		Genesis Eldero  5. Social Security Number	6. Sex	Layr	1111 Ce 7. Age (In yrs.			ilve:	r Spr		8 Date of Bir	th	Mont		ery e (State or	Foreign
Н	Funeral Director		577-44-8557		2[ <b>3</b> F	8	Vre	Months	Days	Hours	Min.	8. Date of Bir (Month, Da April 23	y, Year)	16	Country,	homa	rureign
	<b>D</b>		Usuel Residence of Decedent										, 15.	10	OKIG	ПОща	
	arylar show	-	10a. State 10b. County			10c. Ci	ity, Town or	ocation							10d.	Inside City	
	186-f	Director		ntgo	mery		Silv	er Sp								1 Tes	24 NO
	with the sor		10e. Street and Number 15107 Interla	chen	Driv	a Ant	312	10f. Zip	2090	26			10g. Cit	izen of What	,	7	
	72 hours after death with the Maryland naturel', or Items 23a or 28e-f show diest Evanituer mant be redified at	Funeral	11. Marital Status		Was Dec	edent Ever in U		. Was Dece			igin? (Spe	ecify Yes or No	-	US 14. Race - A		Indian	
9	or Iter	Fun	1 Never Married 2 Mar		Armed Fo	rces? 2 🔀 No						ecify Yes or No Rican, etc.)		Black, W			
93	rel', c	d b	3 ☑ Widowed 4 ☐ Divorced		If Yes, Giv Year or D	e ates:		1 🗆 Yes	2LA No	Specify:				Specify:	Whi	te	
5	72 h "natu	Completed	15. Deceden (Specify only higher				16a. Dec	edent's Usu e kind of wo DO NOT u	al Occupa	ation during mos	t of work	ng	16b. K	ind of Busine	ss/Indus	try	
12	within ane.	dm	Elementary/Secondary (0-12)		College (	-4or 5+)	life	DO NOT u	se retired	)					_		
9	filed Hygie ther ont, II	ပိ	12 17. Father's Name (First, Middle,	Last)			Se	creta	ry	18. Mothe	ar's Name	(First, Middle,		leral	Gove	rnmen	ıt
Maryland 21215-0036	id be ental ked o	To B	Thomas A. Jac								_	ha M. I					
ary	shou ind M mar umat		19a. Informant's Name/Relations	hip <i>(Type</i> ,	Print)		19b. Ma	ling Address	(Street a			l Route Numbe			e, Zip Co	ide)	
	and 2 halth a 127 is er tre		Doris A. Rowe	11/C	ousin		111	0 Sou	th Fo	ox Cu	ь Но	11ow, G	len	Mills	PA	1934	.2
ore	of He		20a. Method of Disposition 1 □ Burial 2 🛣 Cremation	3 🗆 Pom	aval from		Place of Disposemetery, cr	osition (Na	ne of		Marc			cation - City			
Ĕ	Pag ment ent: I	- 1	'4 □ Donation 5 □ Other (S		Ovalitoiti	Me	tropoli	tan Cr	amator	У	200	5	Alex	andria	a, V	irgin	ia
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "naturel", or Items 23a or 28e-f show any injury or other treumatic event, it a Medical Everaliser mant to retilised at ones.		21. Signature of Funeral Service	Licensee	Q.		F	ranci: 500 Un	iver	s of Facilit Coll sity	ins Blvc	Funeral	Hom ilve	ne Inc r Spri	ng,	MD 20	0901
			23a. Part1. Enter the disease, or shock, or heart failure. List	complicat	ions that cause on e	auset the dea									Ap	oproximate tervat Betw	
	Physician		Immediate Cause (Final disease or condition	2	Sen	sis										nset and De	
	/Medical Examiner		resulting in death)			or as a consec	quence of):						-				
	LAGIIIIICI	-	Sequentially list conditions, if any, leading to immediate	b		eumatoi		hritis	3								
	nsit	Examiner	cause. Enter Underlying	<			ceva-										
,	execu n and ial-tra	Exal	that initiated events resulting in death) Last	C.		oth roi									-	·	
8760,	icate be executed physician and s the burial-transit			d.	Ce1	lulitis	5										
9	certifica nding ph use as th	Medi	IF FEMALE:														
Вох	death certific e attending p ed for use as	Physician/Medical	23b. Was decedent pregnant in the past 12 months?	23c.		come of pregni irth 2 🗆 Feta		□Ectopic pi	egnancy				1	23d. Date of	. ,		
0	0 0 0	/slcl	1 Yes 2 No		4☐Pregn 9☐Unkno	ant at time of o	death 5	Other (sp	ecify)		-			Month	Da	у те	ear .
σ.	that the de ed by the a detached		Part II. Other significant condition	ns contrib	uting to de	eath but not res	sulting in the	underlying o	ause nive	n in Part I.		23e, Did to	obacco u	ise contribute	to the c	ause of de	ath?
ds,	Se Co	d by						,,,,,				101	res 2[	<b>3</b> €No 3 🗆	Probably	y 4 □Ur	iknown
COL	~ 9 76	lete		_								24a. Was	an	24b. Were	autonsv	findings as	vailable
Vital Record	9 4 6	Completed										autop perfo	rmed?	prior t death	o comple?	etion of cau	use of
ta	icien: Th certificate rector, pag	co	25. Was case referred to medical							26. Place	of Death	1 Yes	2X No	1 U Y	es 2	J No	
of V	S S S	To B	examiner? 1 ☐ Yes 2 🔀 No	Hos	oital: 1 🔲 I	npatient 2	ER/Outpati	ent 3 🗆 DO	Othe	ar: 4⊠ Nu	rsing Hor	ne 5□Resid	dence (	6 □Other (S	pecify)		
	ding h. After fune		27. Manner of Death  1 Natural 5 Pendin 2 Accident investig	g	28a. Date (Mont	of Injury th, Day Year)	28b. Time Injury	of 2	8c. Injury Work 1 🗆 Y	at ? ′es 2 □ !		28d. Describe h	now injur	y occurred			
Division	in Dirt	Certification:	3 Suicide 6 Could 4 Homicide determ		28e. Place buildi	of Injury - At h ng, etc. <i>(Specil</i>	ome, farm, s fy)	treet, factor	, office		1	28f. Location (S City or Tox	Street and vn, State	d Number or )	Rural Ro	oute Numbe	Эг,
	Hos Hos Bly	Medical C	29a. Certifier (Check only one)  1 Certifyir 2 Medical	g Physici Examiner	On the ba	best of my kno asis of examina ner stated.	owledge, dea	th occurred nvestigation	at the tim , in my op	e, date and inion, deat	d place, a	and due to the dead at the time,	cause(s) date and	and manner place, and d	as stated ue to the	d. e cause(s)	
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifie					290	. License	number			29d. Dat	e signed (Mo	nth, Day	, Year)	
}	770		> Glove	he	20	May	19		D	56691	L			March	7,	2005	
	V	-	30. Name and address of person	who comp	leted caus	e of death (Iter	n 23 <del>a</del> ) (Type	, Print)									
			Ghousia Sulta	na, M		12107	Herita	ige Pa	rk C	ircle	, Si	lver S	orin	g, MD	2090	6	
	Sta Registr		31. Date filed (Month, Day, Year)  MAR 0	2005	32. 9	egistrar's Signa	ture	perte	9								

State of Maryland / Department of Health and Mental Hygiene () Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** MARCH 2005 9:22 A HOLLIDAY ANABET. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** MONTGOMERY LAYTONSVILLE 24428 HIPSLEY MILL ROAD Birthptace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Months Hours 1 ☐ M 2 😿 F 204-26-8001 70 1934 Pennsylvania Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County or 28a-f show the Medical Examiner must be notified at 1 TYes 2 KNo Md. Montgomery Laytonsville Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 20882 United States or Items 23s 24428 Hipsley Mill Road filed within 72 hours after death by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 DNo If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White Specify: 3 ☐ Widowed 4 MrDivorced "neturel", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than . Coltege (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien Important: If item 27 is marked other th any injury or-other traumation. 12 Administrator U. S. Government 4 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Robert W. Leonard Ethel Μ. Frey ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3305 Florence Road, Woodbine, Md. Kathi L. Davis / Daughter r injury as other t 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Metropolitan Crem. 3/09/05 Alexandria, Va. 4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Muriel H. Barber Funeral Home · Banker Mure P. O. Box 5038, Laytonsville, Md. 20882 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tine. Approximate Interval Between Onset and Death tmmediate Cause (Final Years **Physician** ISCHEMIC CARDIOMYOPATHY disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 20 Years HYPERLIPIDEMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit 20 Years DIABETES and Due to (or as a consequence of) attending physician Division of Vital Records, P.O. Box 68760 Physician/Medical А IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Minknown END STAGE RENAL DISEASE Be Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed2 Yes 2 No 1 Yes 2 No certificate Hospitel or Attending Physicien: director 25. Was case reterred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 □Other (Specify) 1 Yes 2 No Certification: To this ( After this funeral d 28b. Time of tnjury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Manner of Death Natural 5 Pending 1 Yes 2 No investigation after death Director: 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide within 24 hours a To the Funeral D 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier m40. MARCH 7, 2005 D 21340 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15225 SHADY GROVE ROAD, #302, ROCKVILLE, MD. 20850 RAYMOND BASS, M.D. 32 Registrar's Signature 31. Date filed (Month, Day, Year) 09 MAR 2005 Registrar

	(5)		1 - For State Registrar	State of Maryland	-	artment of H		lental Hy	giene Reg. No. ()	)5	10090
	Physici	an	Decedent's Name (First, Middle, Last,					2. Date of De Month	ath Day	Year	3. Time of Death
	/Medi		MARY F. HARRIS					MARCH	9	2005	7:50AM M
	Examir	ner	4a. Fecility Name (If not institution, give CORSICA HILLS NU				EVILLE		4c. County QUEEN		L'S
Ŋ	Funeral Director		214-42-9331	7. Age (In yrs. Ias	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, Di JUNE 5	dh	9. Birthpl	ace (State or Foreign try) LAND
poel	* T		Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Lo	cation				10	Od. Inside City Limits
death with the Maryland	fled	ţo	MD QUEEN AI	NE'S	CENT	REVILLE					XXYes 2 □ No
th the	or 28;	Director	10e. Street and Number	1		10f. Zip Code			10g. Citizen of \	What Coun	try?
£.	23a		221 HOPE ROAD			216				USA	
Maryland 21215-0036	or its	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of Hi f Yes, specify Cuba I ☐ Yes 2 ☑ No	ispanic Origin? (Spe in, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		e - America ck, White, e	
5-0	"natursi",	Completed by	15. Decedent's Edu (Specify only highest grade		(Give	tent's Usual Occupa	during most of worki	ing	16b. Kind of B	usiness/Ind	ustry
121 Within	I Hygiene. other than '	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)		OO NOT use retired OMEMAKER	0		OLIN	ПОМЕ	
20 20	Hygi ent.	0	17. Father's Name (First, Middle, Last)	0	п	PIEMAKEK	18. Mother's Name	(First, Middle	OWN , Maiden Suman		
lan de la	nd Mental marked matic sv	To B	EARL CALLAHAN				MARY W	нтте			
laryla Should	and N		19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailir	g Address (Street a	and Number or Rura		er, City or Town,	State, Zip	Code)
	f Health and Mer itsm 27 is marke other traumatic		LYNDA H. PALMATARY				ARTIN ROA				
Baltimore,	0		20a. Method of Disposition 1 ₺ Burial 2 □ Cremation 3 □ R		netery, crer	sition (Name of natory or other plac		Date	20c. Location -	City or Tov	wn, State
Itim	는 분들 .		<ul><li>4 □ Donation 5 □ Other (Specify)</li><li>21. Signature of Funeral Service License</li></ul>				TERY 3-15	-2005	CENTRE	VILLE	• MD
Ba	Depa Impo any i				F	Name and Addres	ELFENBEIN	& NEW	IAM FUNE	RAL H	OME PA
	100		23a. Part1. Enter the disease, or compli	EXCERO Cations that caused the death.			RISON ST g, such as cardiac o				Approximate
P	hysician		shock, or heart failure. List only or Immediate Cause (Final	e cause on each line.	12:00	110					Interval Between Onset and Death
	Medical		disease or condition resulting in death)	Due to (or as a conseque	nce of):					- 6	cays.
E	xaminer		Sequentially list conditions,	Septem						6	Va1/5
Pe	sit	lner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	nce of):	0 . 4					/_
xecut	and al-tran	Examine	that initiated events resulting in death) Last	Due to for as a conseque	væs Cu nce of):	ilai a	3			4	ears
8760, sate be executed	ohysicien and the burial-transit	dlcai E					_				
	g phy as the	edic									
O. Box 6	ed by the attending p detached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	3c. If yes, outcome of pregnanc 1 □ Live birth 2 □ Fetal d 4 □ Pregnant at time of dea 9 □ Unknown	eath 3	Ectopic pregnancy Other (specify)			23d. Dat Mo	e of deliver	y Day Year
<b>⊡</b>	ed by detac		Part II. Other significant conditions cor	tributing to death but not resulti	ing in the ur	iderlying cause give	en in Part I.	23e. Did t	obacco use conti	ribute to the	cause of death?
ds	n sign ald be	d by	upper gastroi	n testinal ble	ed			1 🗆	Yes 2 No	3 🗌 Proba	bly 4 Unknown
000	s beer	Completed	anomia					24a. Was	an 24b. V	Vere autop	sy findings available
The t	ite ha	mo						autor perfo	rmed?	leath?	pletion of cause of
of Vital Physician:	ertifica ctor. p	BeC	25. Was case referred to medical examiner?				26. Place of Death				
of V	this ce	ျှ	1 ☐ Yes 2 🗷 No	ospital: 1 ☐ Inpatient 2 ☐ EF			4 X Nursing Hor	ne 5 🗆 Resi	dence 6 🗆 Othe	er (Specify)	
Sing F	After funera	lon:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	8b. Time of Injury	28c. injury Work	(?	28d. Describe	how injury occurr	ed	
Division of Vital Records,	after death.  Director: A  in by the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, stre		res 2□No	28f. Location ( City or To	Street and Number vn, State)	er or Rural	Route Number,
To the Hospitel	within 24 hours after death.  To the Funeral Director: After this certificate has been signed completely filled in by the funeral director, page 2 should be de	edical	29a. Certifier 1 Certifying Physics (Check only one) 1 Certifying Physics 2 Medical Examination	ician: To the best of my knowle ler: On the basis of examination and manner stated.	edge, death n and/or inv	occurred at the tim estigation, in my op	ne, date and place, a pinion, death occurre	and due to the ed at the time,	cause(s) and ma date and place, a	nner as sta and due to t	ted. the cause(s)
, I	within 2 To the	Σ	29b. Signature and title of certifier	leer Herry		29c. License	number		29d. Date signed	(Month, D	ay, Year)
1	51	1	30. Name and address of person who co			Terrorette terrent					
	Sta	te.	KATHLEEN HOEY M.D. 31. Date filed (Month, Day, Year)	<ul> <li>2540 CENTREV</li> <li>Registrar's Signatur</li> </ul>	TLLE	ROAD, CEN	TREVILLE,	MD 21	617		
	Registr		444	And A	A	0					
DHMH	1 17 Rev 1/20	001	*								
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State of Maryland / Department of Health and Mental Hygiene UUD For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** JAMES 03 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE SALTIMO RE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 5. Social Security Number 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) **Funeral** Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits 28e-f show Examiner must be notified Director 1 ☐ Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 5 8965 Items 23e 21601 Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "naturel', or 1 Yes 2 No þ Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 7 is marked other then "natured treumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 MASON CONSTRUCTION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental CHARLES F. HARRISON MARY EASON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Importent: If item 27 is eny injury or other tret ODGE. BEATRICE HARRISON/WIFE 8965 WILLOW ROAD, EASTON, MD 21601 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) UPPER BAMBURY CEMETERY 3-17-2005 TRAPPE, MARYLAND 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.

Approximate 22. Name and Address of Facility Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Dheumoni A /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence offs Examiner The law requires that the death certificate be executed burial-transil Due to (or as a consequence of) Box 68760, attending physician for use as the burial by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Live birth 2 Fetal death in the past 12 months? Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? page 2 s certificate has 2 No 1 TYes or Attending Physicien; filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 2 No 1 🗌 Yes patient Certification: To 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Division 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely To the 29b. Signature and title of certifier 05 Name and a ress of person who completed cause of mathy tem 23a) (Type, Print) UNIVOF MARYLAND MEDICAL CENTER Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

**ORIGINAL** 

3 Registrar's Signature

MAR 1 6 2005

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2005 12:45 AM Addie E. Hayes March 7, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Holy Cross Hospital Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye, April 1, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** . 1919 Virginia Months Days Hours Min, 1 M 2 XF 85 577-26-7108 Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location Show 10b. County 10d. Inside City Limits The Medical Examinar must be notified at 1 X Yes 2 No Maryland | Montgomery Silver Spring Director or 28e-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1316 Fenwick Lane 20910 #807 United States or Items 23e death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after C Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Iter Importent: If item 27 is marked other then "neturel", or Iter Department of other treumetic event, Ire Medical Examinations. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ 3 Widowed 4 □ Divorced ear or Dates: African American Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Real Estate Entrepreneur 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John T. Williams Alma Carpenter 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marian Miller 4201 Cathedral Ave. N.W., #223W, Wash. D.C. (Niece) 20016 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/9/05 Beltsville, Maryland Chesapeake Crematory 22. Name and Address of Facility McGuire Funeral Service 21. Signature of Funeral Service Licensee 7400 Georgia Ave. N.W., Washington, D.C. 23a. Party. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Stroke sudden /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 attending physician Physiclan/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) 4□Pregnant at time of death Division of Vital Records, P.O. the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Seizure disorder 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy rmad? 200 No certificate 1 Yes To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Xnpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 ☐ Yes 2X No ၉ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) the funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 T Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 32332 March 7, 2005 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SK Gupta, M.D. 9801 Georgia Avenue #220, Silver Spring, MD 31. Date filed (Month, Dav. Year) State MAR 1 0 2005 Registrar

05-18 DOS	897	1 - State Registrar	State of Maryl		artment of F rtificate of			eg. No. UU	5 10093
	Physician /Medical Examiner	DWIGHT ORLA      DRIGHT ORLA      As. Facility Name (If not institution, g	NDO HUBBARD			Location of Death	Month March 1	Day 2005	7 (Pear 1817 p M Death
	Funeral Director	Memorial Hospita  5. Social Security Number  214-70-6162	Sex 7. Age (In y	rrs. last birthday) 45 Yrs.	Easton  If Under 1 Year  Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 6/4/195	Talbot  Year)  N	9. Birthplace (State or Foreign Country) Maryland
	Maryland -1 show filed ut	Usual Residence of Decedent  10a. State 10b. County Caro1:	ine 10c.	City, Town or Lo	ocation Pre	eston	×1.11 ±22		10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	fler death with the Mar r Items 23a or 28e-1 sh fret must be to diffied Funeral Director	10e. Street and Number 4669 Gadow's Ro	ad		10f. Zip Code 216	555	,	og. Citizen of Wh United S	•
036	by	11. Marital Status 1 √ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Origin? (Spe in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		American Indian, White, etc. Black
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e, Mar	1 and 2 sh Health and em 27 1s m ther traum	Justa E. Hubbard, 20a, Method of Disposition	/Mother	4669	Gadow's H	and Number or Rura	on, Mary	land 21	tate, Zip Code)  .655 ity or Town, State
Iltimor	nit. Pages artment of ortent: If it injury or o	1 Surial 2 Cremation 3 4 Donation 5 Other (Spec	Co	oppins A	osition (Name of matory or other place ME Cemete 2. Name and Addre	ery 3/21/	2005		Maryland
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sion of	To the Hospitel or Attending Physicien: The within 24 hours after death.  To the Funerel Director: After this certificate ha completely filled in by the funeral director, page  Medical Certification; To Be Com	27. Manner of Death  1 Avatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year	The second second	of 28c. Injur Wor			w injury occurred	
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	To the comp	29b. Signature and title of certifier			29c. Licens		M	arch 16,	Month, Day, Year) 2005
		30. Name and address of person wh	o completed cause of death (	Item 23a) (Type,		nn Street	Baltim	nore. Mai	ryland 21201
	State Registrar	31. Date filod (Month, Day, Year) MAR 1 8 20	32. Registrar's Si	ignature					

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			1. Decedent's Name (First, Midd	le, Last)	<u></u>		,		2. Date of D Month	-	, v	ear	3. Time of Death
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	Examin		4a. Fecility Name (If not institution	n, give street and n	umber)		4b. City, Town, o	or Location of Dea	th		County of		
			Carriage Hill	Nursing H			Bethes				ntgon		
	Funeral Director		5. Social Security Number 022-01-7880	6. Sex 1 ☐ M 2 💢 F		yrs. last birthday) 7 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min					lace (State or Foreign try) Lsea, MA
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	ns 2%	era	11. Marital Status	12. Was De	cedent Ever	in U.S. 13.	Was Decedent of H	Hispanic Origin? (	Specify Yes or N	0-	14. Race -		
2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Healih and Mental Hylgiene. Importent: If them 27 is marked other then "neturel; or items 23e or 28e-f show eny injury or, other treumatic event, the Medical Examiner must be mullified at one injury or.	oy Fur	1 ☐ Never Married 2 ☐ Ma 3 ∏ Widowed 4 ☐ Divorce	IT YAS. (	2 X No live		If Yes, specify Cub 1 ☐ Yes 2 🏋 No	an, Mexican, Puer Specify:	rto Rican, etc.)		Black, Specify:	White, o	etc. ite
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2	12 sh h and 7 Is m Treum	7. 3	19a. Informant's Name/Relation Brenda Gerwin/				ng Address (Street Hampden			-		ate, Zip	Code)
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2	ages int of t: If it		1 🌠 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (		n State				.,				
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_	spitel ours a		29a. Certifier 1 Certify	ing Physician: To t	he best of my	/ knowledge, deal	th occurred at the ti	ime, date and place	e, and due to the	e cause(s)	and mann	er as st	ated.
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	10		30. Name and address of perso					m 0001/					
			Steven Swartz,					ш 20814			-		
	Sta Registi		31. Date filed (Month, Day, Yea	2005	registrar's S	Signature	and I						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 5 10095 Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Day Month Year **Physician** February 19. 2005 9:10 A Harold Jenkins /Medical 4c. County of Deeth 4b. City. Town, or Location of Death 4e. Fecility Name (If not institution, give street and number) Examiner Howard Columbia Vantage House If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Dey, Yeer) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**∑**M 2□F Yrs. North Carolina Director July 4, 1913 240-14-0025 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County Pages 1 and 2 should be filled within 72 hours after death with the Marylan nent of Health and Mental Hygiene.
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Other than "natural", or Itel Types 2 □ No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married 1 ☐ Yes 2√2 No Specify Specify Baltimore, Maryland 21215-0036 Completed by 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Etementary/Secondary (0-12) Coltege (1-4or 5+) U.S. Government 10 Police Sergeant 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 Alvarada Smith Pulaski Webb Jenkins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) 20110 Charles H. Reedy/Friend 10108 Grant Ave, Manassas, VA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of H
Important: If its
any injury or of 1 Burial 2 Cremation 3 Removat from State
4 Donetion 5 Other (Specify) Forest Hill Cemetery Feb 23, 2005 Nashville, NC 22. Name and Address of FacilityHines-Rinaldi Funeral Home 21. Signature of Funeral Service Licensee amell Ola 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List-only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner simisitis extensive Po rangse Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed roste physicien ar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical as t ed by the attending p detached for use as tE FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) 4☐Pregnant at time of death 9 Unknown n signed by the 23e. Did tobacco use contribute to the cause of death? Part It, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 | Yes 2 No 3 | Probably 4 | Unknown Be Completed peeu 24a, Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? this certificate has 2010 2 No 1 Yes bre or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Mennes of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28d. Describe how injury occurred Intury within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident the 1 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 4 Homicide Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Dev. Year) 29b. Signature and title of certifier 29c. License number

State Registrar

DHMH 17 Bev 1/2001

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32. Registrar's Signature

ousuille

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2005

413 commonweatth AV

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31. Date filed (Month, Day, Year)

1.1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] 5 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 1:00 PM M March 6, 2005 Agnes Doris Jones /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 23770 Ruth's Way Hollywood Mary's If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 ☐ M 2 💢 F Director 219-58-8004 85 July 22, 1919 \_Maryland Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Importent: If item 271s marked other than "natural", or Items 23a or 28e-1 show any Injury or other traumetic event, the Madical Examinational to notified at 1 Yes 2 No Director St. Mary's Maryland Hollywood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23770 Ruth's Way U.S.A. 20636 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes XXNo Specify: à If Yes, Give Year or Dates: 3XXWidowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Maker 12 Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Joseph Beavan Agnes Liqouri Abell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Alan Jones / Son 23770 Ruth's Way Hollywood, Maryland 20636 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ▼Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) Holy Face Cemetery 3-10-05 Great Mills, Maryland 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Libensee Edua a P.O. Box 279 Leonardtown, Maryland 20650-0279 1100052 23a. Part1. Enter the disease, or comprications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. one cause on each line Immediate Cause (Final disease or condition resulting in death) Center Cardwistelling Orrow Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ed by the attending physicien and datached for use as the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Dav Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 A No 9 ☐ Unknown Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 2 No 1 Yes To the Hospital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 54 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 Yes 2 □ No hours efter death. inerel Director: After this y filled in by the funeral d 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours e Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Owithin 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 1714581 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5

DHMH 17 Rev 1/2001

State

Registrar

William Boyd II, M.D.

31. Date filed (Month, Day, Year)

32. Registar's Signature

2005

25365 Point Lookout Road Leonardtown, Maryland 20650

		State of Maryland / Department of Health and Months of State Unpend Item 23a,pt.II,27 per me Cantal 38005 trans	/	05	10097
Physicia /Medic Examin	al	1. Decedent's Name (First, Middle, Last)  Pauline Mary Lizzy Jen Kins  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	2. Date of Death Month MARCH 1	Day Year 6, 2005	3. Time of Death 5:29 P M
Funeral Director	اب	EASTON MEMORIAL HOSPITAL  5. Social Security Number  1 M 2 F	8. Date of Birth (Month, Day, Y	VOL /	CO  thplace (State or Foreign puntry)  1 aryland
with the Maryland	Funeral Director	Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or Location  St. M: Chaple  10c. Street and Number  10f. Zip Code	109	. Citizen of What Co	10d. Inside City Limits 1 (12 Yes 2 ☐ No
1215-0036 Hell with the Marylar ann.  Then "natural", or Items 23a or 28a-f show ite Marylar and items 23a or 28a-f show ite Marylar Exercities and items 23a.	by	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married 3 Widowed 4 Dovorced  15. Decedent's Education  16a. Decedent's Usual Occupation		14. Race - Ame Black, Whit Specify: B	e, etc.
Maryland 21215 d 2 should be filed within 72 th and Mental Hygiene. 27 is marked other than "na traumatic event, the Media	Be Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  College (1-4or 5+)  College (1-4or 5+)  (Give kind of work done during most of working life. DO NOT use retired)  ASSIST, MR, Howse K1  18. Mother's Name	eeping	Hote	/
	OT.	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural  Nathan Lamar White 24+05 Chester Par  20a. Method of Disposition  1 Maurist 2 Cremation 3 Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)	K Lane	St.Mich Location - City or	Town, State
Baltimore, permit. Pages 1 as Department of Hea Important: If item any injury or othe		21. Signature of Funeral Service Licensee  22. Name and Address of Facility  23a. Part Enter the disease, or complications that caused the death Do not enter the mode of dying, such as caudiac or shock, or heart failure. List only one cause on each line.	HOME, N St. C	P.A. ambrida	Maryland  Approximate Interval Between Onset and Death
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	Physician/Medical	d.  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown  5 Other (specify)		23d. Date of del Month	ivery Day Year
	Completed by Pf	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Hypertensive Cardiovascular Disease	23e. Did tobac		the cause of death?
Vital Rec	Be Compi	25. Was case referred to medical examiner? 26. Place of Death	24a. Was an autopsy performed 1 12 Yes 2 (Check only one)	prior to death?	topsy findings available completion of cause of
Division of Vital Records, To the Hospital or Attanding Physician: The law requires to within 24 hours after death.  To the Funeral Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be	Certification; To E	1 XYes 2 No Hospital: 1 Inpatient 2 XER/Outpatient 3 DOA Other: 4 Nursing Hom  27. Manner of Death 1 XNatural 5 Pending 2 Accident investigation  1 Accident 2 XER/Outpatient 3 DOA Other: 4 Nursing Hom 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 1 Yes 2 No 28c. Injury at Work? 1 Yes 2 No	e 5 Residenc	e 6 Other (Specinjury occurred	cify)
Division or the Hospital or Attanding within 24 hours after death. To the Funeral Director: Atter completely filled in by the tuner		building, etc. (Specify)  29a. Certifier  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and place are the specified of the sp	City or Town, S	e(s) and manner as	stated
To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	29b. Signature and title of certifier  29c. License number  OCME  30. Name and address of person, who completed cause of death (Ipem 23a) (Type, Print)	d at the time, date	Date signed (Month ARCH 17,	to the cause(s)  n, Day, Year)  2005
Stat Registra	T.a.	CAROCH ALANMA 111 Penn Street Bal  31. Date filed (Month, Park Park) 1 2005 32. Resistrar's Signature	timore,	Maryland	21201

			1- For State of Maryland	-	rtment o				giene	5 10098
	Physici /Medic		Decedent's Name (First, Middle, Last)     Maggielien	King	S			2. Date of Dea	Day	Year 9 9 2005
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, To	wn, or Locat	tion of Death		4c. County	of Death
			Washington County Hospital	4114		gersto				ington
I	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last 1 ☐ M 2 1 ☐ F 76		If Under 1 \ Months D	Pays Hou	nder 24 Hrs. urs Min.	8. Date of Birtl (Month, Day Sept • 1	7 1928	9. Birthplace (State or Foreign Country) Virginia
	land		Usual Residence of Decedent  10a. State 10b. County 10c. City, T	own or Lo	cation					10d. Inside City Limits
	Mary If sh	to	MD. Washington Ma	ugans	ville					1 □ Yes 2 No
	with the	Funeral Director	10e. Street and Number 13847 Greenfield Ave.		10f. Zip Co	767			10g. Citizen of	What Country?
	death	nera	11. Marital Status 12. Was Decedent Ever in U.S.	13. y			c Origin? (Spe	ecify Yes or No- Rican, etc.)		ce - American Indian,
39	s within 72 hours after death with the Maryland liene. r than "naturel", or Items 23a or 28a-f show the Medical Exacines must be rodified at	by Fui	Armed Forces?  1 Never Married 2 Married 1 Yes 2 No If Yes, Give  Year or Dates:		Yes, specify		xican, Puerto ecify:	Hican, etc.)		ck, White, etc. y: White
Maryland 21215-0036	"nature	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	lent's Usual C kind of work of OO NOT use i	done durina	most of worki	ng	16b. Kind of B	usiness/Industry
212	f within jiene.	ошо	Elementary/Secondary (0-12) College (1-4or 5+)		·/Opera				Cerami	c Business
br	Hyg the	BeC	17. Father's Name (First, Middle, Last)		7 9 7		lother's Name	(First, Middle,		
ylar	should be ind Mental imarked c	To	Edgar Lee Hensley				Rosie	Lee Mor	ris	
Mar	s 1 and 2 should f Health and Mer item 27 is marke othar treumatic				-					State, Zip Code) rille Md. 21767
	s 1 and f Healt item 2 other		20a. Method of Disposition 20b. Place	e of Dispo	sition (Name	of		Dox 431		City or Town, State
E	0 0		1 Medurial 21 Cremation 31 Removal from State 1	-	natory or other Cemete		3/18	/05	Greenc	astle, Pa.
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensee  H. Martin Jummerna S	- \ Z	Name and A Immern 5 S C	Address of F nan An Carlis	acility d Son le St.	Funeral Greenc	Home I	nc. Pa. 17225
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9	rtificate ng physi as the	P								
Вох	eath certific attending p for use as (	Physician/M	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal de	ath 3	Ectopic pregi				1	te of delivery onth Day Year
o.	that the dended by the a	nyslc	1 ☐ Yes 2 ☑ No 4☐ Pregnant at time of death 9 ☐ Unknown 9 ☐ Unknown	n 5L	Other (speci	ry)				
s, P	8 10 0	by	Part II. Other significant conditions contributing to death but not resulting	ng in the ur	nderlying caus	se given in P	art I.			ribute to the cause of death?  3 Probably 4 Dunknown
örc	w require been sign	eted						24a. Was a		
Records,		Completed						autop perfor	med?	Were autopsy findings available prior to completion of cause of death?  1  Yes 2  No
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Division	el or Attendin s after death. if Director: Af id in by the fur	Certification;	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At home building, etc. (Specify)	e, farm, stre	eet, factory, o	ffice		28f. Location (S City or Tow		per or Rural Route Number,
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)	vithii To th	W	29b. Signature and title of certifier  Author  A	10	29c. L	icense numl	5 8 5		29d. Date signe	d (Month, Day, Year)
	ID		30. Name and address of person who completed cause of death (Item 23	Ba) (Type,	Print)	10 n	or 1	taz IM	1 2	747
	Sta	ite	31. Date filed (Month, Day, Year) 32. Magistrar's Signature			m 14	r I	100	w C	/ [ -
	Registi	rar	MAR 2 4 2005 Menus D	19						

			For State Registrar	State of	Marylan	d / Depa <i>Cei</i>	artment of H	ealth a Death	ind Mental	Hygie		1009	9
			Decedent's Name (First, Middle, La	st)				-	2. Date	of Death		3. Time of Dea	th
	Physici /Medic		Virginia	Joan E	Kelley				Mont	h 7,	Day Ye 2005	10:08 I	РМ
	Examin		4a. Facility Name (If not institution, giv				4b. City, Town, or	Location o			4c. County of E	Death	
			Byron House				Potoma				Montgom		
	Funeral		5. Social Security Number 6. S	ex	. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. 8. Date	of Birth h, Day, Ye 1 25,	9.	Birthplace (State or For Country)	reign
Ь	Director		Usual Residence of Decedent		89	113.			Marci	1 25,	1915 N	ew York	
	yland		10a. State 10b. County		10c. Cit	y, Town or Lo	cation					10d. Inside City Lin	nits
	a-f st	to	D.C. None			Washi	ngton					1X Yes 2 □	No
	or 28	Director	10e. Street and Number				10f. Zip Code			10g.	Citizen of Wha	t Country?	
	ath w	rai	4816 Alton Place				200				USA		
	er des	Funerai	11. Marital Status	12. Was Deced	eş?	S. 13.	Was Decedent of His f Yes, specify Cubar	spanic Orig n, Mexican	gin? (Specify Yes) , Puerto Rican, etc	or No- c.)		American Indian, Vhite, etc.	
ა ზ	rs aft	by F	1 ☐ Never Married 2 ☐ Married  3 🏝 Widowed 4 ☐ Divorced	1 ☐ Yes If Yes, Give Year or Da			1 ☐ Yes 2X No	Specify:			Specify: W	hite	
ş	2 hou atura		15. Decedent's E	ducation		16a. Dece	dent's Usual Occupa	tion		166	. Kind of Busine		
2	hin 7 9. 9n "n Med	ple	(Specify only highest gra Elementary/Secondary (0-12)	College (1-	4or 5+)	life.	kind of work done d DO NOT use retired)	uring most	or working				
7	be filed within 72 hours after death with the Maryland tal Hyglene. dother than "natural", or Itams 23a or 28a-1 show event. I're Medical Exam avent. I're Medical Exam had not a confiled at	Completed	12			Home	maker					Home	
Ē	be fill d oth	Be	17. Father's Name (First, Middle, Last,					18. Mothe	r's Name (First, M		den Sumame)		
Maryland 21215-0036	jes 1 and 2 should be filed within 7 of Health and Mental Hygiene. If item 27 is marked other than "r other traumatic event, the Med	L C	John White  19a. Informant's Name/Relationship (	Tuno Print)		10h Mailie	ng Address (Street a	nd Numbo	Mary Mag		ity or Tourn Sta	to Zin Codol	
<u>a</u>	d 2 sl th and traur		Jean Lively/Daug				Alton Pla				•		
യ്	Heal Heal tem 2		20a. Method of Disposition	11001	20b. P	lace of Dispo	sition (Name of		Date	<del>_</del>		or Town, State	
P F	Sent of Sent o		1 ABurial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Special		tate		matory`or other place National		ar.10,200	15	Calver	ton, NY	
Baltimore,	permit. Pages Department of H Important: If ite any injury or of		21. Signature of Funeral Se		1 -		2. Name and Addres					2011, 111	
ñ	Per La		hua 18 100	11		22	22 Wiscon	sin A	Ave., NW.,	Wash	.,DC 200	007	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that ca	used the deatl ch line.	n. Do not ent	er the mode of dying	, such as	cardiac or respirat	ory arrest,		Approximate Interval Between	1
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	/Medical Examiner		resulting in death)	Due to (c	r as a conseq	uence of):							
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Box	death certific e attending p ed for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?		th 2 Feta	Ideath 3	Ectopic pregnancy				23d. Date of Month	delivery Day Year	
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ď	requires that the been signed by th hould be detache		Part II. Other significant conditions	contributing to dea	ath but not res	ulting in the u	nderlying cause give	n in Part I.	23e.	Did tobacc	co use contribut	te to the cause of death	?
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CO	> 10	lete							24a.	Wasan	24b. Were	e autopsy findings availa	able
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Vital Record	ician: Th certificate rector, pag	0	25. Was case referred to medical					26. Place	of Death (Check	- 11	NO I	165 2 100	
<u>=</u>	nysici lis cer direc	To B	examiner? 1 ☐ Yes 2 🛣 No	Hospital: 1 ☐ In	patient 2	ER/Outpatier	nt 3□ DOA Othe	T. 4 🗆 Nui	rsing Home 5	Residence	e 6 ⊠Other (5	Specify) Assist	
0	ding Phys h. After this c funeral dir		27. Manner of Death  1 Autural 5 Pending	28a. Date of (Month)	Injury , Day Year)	28b. Time o Injury	Work	?		ribe how i	njury occurred	Living	
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Division of	or At after of Diraci in by	Certification:	4 Homicide determined	280. Place	of Injury - At ho g, etc. <i>(Specif</i>	ome, tarm, sti y)	eet, factory, office			or Town, S		r Rural Route Number,	
_	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Diractor: After this certifical completely filled in by the funeral director.		29a. Certifier 1 X Cartifying PI	lysician: To the	best of my kno	wiedge, deat	n occurred at the tim	e, date and	d place, and due to	the cause	e(s) and manne	r as stated.	
	e Hos 24 h e Fur letely	edical	(Check only one) Medical Example (Check only one)	niner: On the ba and mann	sis of examina er stated.	tion and/or in	vestigation, in my op	inion, deat	th occurred at the	time, date	and place, and	due to the cause(s)	
	Vithir To th comp	Me	29b. Signature and title of certifier	1//			29c. License					lonth, Day, Year)	
j	5		Acmuel U	Jeery	MI		25992			Ма	rch 8,	2005	
			30. Name and address of person who	completed cause									0
			Daniel V. Young	7		Conne	cticut Av	e. N.	W. #104	Wash	nington,	, D.C. 2000	8
	Sta Registi		31. Date filed (Month, Day, Year)  MAR 0 9 2		gistrar's Signa	F. 10	eve						
			1419 ***	1									

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. NO. 0 0 5

			1- State of Maryland / Department of Health a State of Maryland / Department of Health a Certificate of Death	•	rgiene Reg. No. 005	10100
ı	Physici	an	1. Decedent's Name (First, Middle, Last)  Phyllis T. Kaylor	2. Date of De Month March	Day Year	3. Time of Death 6:05 P M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)  Washington Adventist Hospital  Takoma Pa	of Death	4c. County of Dea	
	Funeral Director			r 24 Hrs. 8. Date of Bi	rth 9. Bir	thplace (State or Foreign ountry) W York
	land ow		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location			10d. Inside City Limits
	e Many 8a-f sh	Director	Maryland Prince George's College Park	· · · · · · · · · · · · · · · · · · ·		1 ☑Yes 2 ☐ No
	th with th	al Dire	10e. Street and Number 9007 St. Andrew's Place 20740		10g. Citizen of What Co USA	ountry?
980	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland arment of Health and Mental Hyglene. ortant: If item 27 is marked other then "neturel", or items 23a or 28a-f show injury appealing training the routile at the most of the routile	by Funeral	11. Marital Status  1 Never Married  2 Married  3 Xwidowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 Xwidowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 Xwidowed 1 Yes, Sive  13. Was Decedent of Hispanic Or If Yes, specify Cuban, Mexical If Yes, Sive  14. Was Decedent Ever in U.S. Armed Forces?  15. Was Decedent of Hispanic Or If Yes, Specify Cuban, Mexical If Yes, Sive  16. Yes 2 Xwidowed 1 Yes 2 Xw	an, Puerto Rican, etc.)	o- 14. Race - Ami Black, Whi Specify: Wh	te, etc.
21215-0036	filed within 72 ho Hygiene. Ither then "netur ant, I. w. Jicall	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  2  16a. Decedent's Usual Occupation (Give kind of work done during mos life. DO NOT use retired)  Administrator	ost of working	16b. Kind of Business	
	be filed with tal Hygiene d other the event, I'e	Be Co		ner's Name (First, Middle	L	OVELIMENTE
ylaı	2 should be and Mental Is marked creumetic ever	Tof		roline S. S		
Maryland	nd 2 sh lith and 27 Is n		19a. Informant's Name/Relationship ( <i>Type, Print</i> )  Richard L. Kaylor/ Son  19b. Mailing Address ( <i>Street and Numb</i> 5604 Linwood Cour			
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 It any injury gether tre gnce.		20a. Method of Disposition  1 № Burial 2 □ Cremation 3 □ Removal from State  1 □ Donation 5 □ Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Fort Lincoln Cemetery	March 12, 2005	20c. Location - City or Brentwood,	
Balti	permit. Departm Importa any inju		21. Signate Funeral Service Licensee Cole Francis J. Col. 500 University	lins Funera Blvd, W, S	l Home Inc ilver Sprin	g, MD 20901
No. of Concession, Name of Street, or other Persons, Name of Street, or ot	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or commiscations that caused the death. Do not enter the mode of dying, such as shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a			Approximate Interval Between Onset and Death
68760,	ficate be executed physician and is the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):			
O. Box 687	death certif e attending ed for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   2   No 9   Unknown   23c. If yes, outcome of pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnancy   5   Other (specify)   9   Unknown   5   Other (specify)   1   1   1   1   1   1   1   1   1		23d. Date of de Month	livery Day Year
rds, P.	w requires that the been signed by the should be detached	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part		tobacco use contribute to	o the cause of death?
Vital Records,	The law ate has b page 2 sl	Completed		24a. Was auto perfi 1 \( \text{Yes}	opsy prior to death?	utopsy findings available completion of cause of
Vita	Physician: Th this certificate ral director, paç	o Be	examiner?	ce of Death (Check only		
of	Attending Physic death. ector: After this by the funeral di	-	1		how injury occurred	city)
Division	in Dir	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		(Street and Number or Riwn, State)	ural Route Number,
	d the	edical	29a. Certiflier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date an analysis of examination and/or investigation, in my opinion, death occurred at the time, date an analysis of examination and/or investigation, in my opinion, death occurred at the time, date and manner stated.	and place, and due to the eath occurred at the time,	, date and place, and due	e to the cause(s)
)	To the twithin 2. To the to complet	Σ	29b. Signature and title of certifier USS / L  29c. License number  D 4 3	471	29d. Date signed (Mont	h, pay, Year)
	4		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  HOUSE KIEGUSSIEM. D. WOSI	hinston	Advent	9- HOS
	Sta Registi	- 1	31. Date file of Month, Day, Year)  MAR 1 0 2005  MAR 2 0 2005		,	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Lechliter MARCH Hershel 2005 15:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MEMORIAL HOSPITAL CUMBERLAND ALLEGANY If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Sep 24, 1935 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1√2 M 2□ F Director 212-34-1733 69 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23s or 28a-f show any injury or other traumatic event, the Medical Exercite trained at Ance. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits WV Mineral Wiley Ford No Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 26767 USA P.O. Box 662 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No IXYes, Give Year or Dates: 1953-55 1 Never Married 2 Married Specify: white 1 ☐ Yes 2 No Specify: þ 3¥ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Correctional Officer State of Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Anna (Simpson) Lechliter Walter Lechliter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rt. 2 Box 576 Ridgeley WV 26753 Janet Pyles sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 3/20/2005 WV Lechliter-Monnette Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Short Gap 22. Name and Address of Facility
Scarpelli Funeral Home, PA 21. Sign of Funeral Service Licens, e 108 Virginia Avenue: Cumberland, MD 21502 P. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, now, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Pulmonary Disease a. Chronic Obstructive disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Fibrillation itrial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as consequence of): attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has lirector, page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 M Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No 2 this 27. Manner of Death

1 Natural
2 Accident 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Yes 2 No after death Diractor: / 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide within 24 hours a 🟗 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D0062429 March 17,2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ave. Cumberland, MD. 21502 0 Saleem M.D. 500 Memorial Ageel 32. Registrar's Signature State Registrar

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed

Hospital or Attending Physician:

Division of Vital Records, P.O. Box 68760,

	1 - For State Registrar	State of M	aryland / Dep <i>Ce</i>	ertificate of			giene	5 1	010	)2
	1. Decedent's Name (First, Middle,	Last)				2. Date of De		Year	3. Time of	Death
Physiciar /Medica		art 		.,		March	7, 2005		4:28	a <sup>M</sup>
Examine	4a. Facility Name (If not institution,			4b. City, Town, o		th	4c. County			
	Suburban Hosp  5. Social Security Number  6		je (In yrs. last birthda)		thesda	s. 8 Date of Bird	th		omery	
Funeral Director	236-01-9380	1 □XM 2 □ F	90 Yrs.	Months Days	Hours Min	8. Date of Bin (Month, Da March	iÿ, Year) B <b>,</b> 1914	Counti	y) Virgi	-
	Usual Residence of Decedent		40. O't. T.					10	d 11d- 01	
arylar	10a. State 10b. County	ontcomoru	10c. City, Town or I	ocation cville				10	<ul><li>d. Inside Ci</li><li>1 ☐ Yes</li></ul>	·
with the Mar or 28a-1 st	Maryland M  10e. Street and Number	ontgomery	ROCI	10f. Zip Code			10g. Citizen of V	What Count		
with t		overs Wav		208	352		rog. Okt.zom or t	USA	-	
d 21215-0036 filled within 72 hours after death with the Maryland Hygiene. thar then "neturel", or Itams 23a or 28a-f show ant, If a Medical Ever it at mant be notified at	11. Marital Status	12. Was Decedent	Ever in U.S. 13	. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (	Specify Yes or No	14. Rac	e - America		
or Its	1 ☐ Never Married 2 🔀 Marrie	d 1 ☐ Yes 2 🛱 If Yes, Give		1 ☐ Yes 2 ☐ No	Specify:	nto riioan, etc.)		ok, White, e ∵ Whit		
5-003 72 hours "netural",	3 Widowed 4 Divorced	Year or Dates:	1 450 000							
15-0	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	grade completed)	(Giv	edent's Usual Occup e kind of work done DO NOT use retire	during most of we	orking	16b. Kind of B	ısınessındı	ustry	
212 3 withi jiene.	Elementary/Secondary (0-12)	College (1-4or		Parts Mana	ager		Contra	ctor	Suppl	.y
and 212: be fliad withintal Hygiene. ad other then event, it a.m.		ast)				ame (First, Middle,		10)		
Vlat buld b Mente arkad	Henry A. Lock					nce E. F				
, Maryland 21215-0036 and 2 should be filed within 72 hours alt eath and Mental Hygiene. The Trist marked other then "neturel; or her traumatic event, It a Medical Entries.	19a. Informant's Name/Relationshi Maxine Darr/ N			ling Address <i>(Street</i> Brook Gle						
Baltimore, M permit. Pages 1 and 2 Department of Health Importent: if item 27	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation		·	ematory or other plac	i ria	Date rch 10	20c. Location -	•		
it. Pa	* 4 □ Donation 5 □ Other (Special Service Li			ill Cemete		2005	Charles		WV	
Balti Permit. Departi Importe eny inji	21. Signature of Pulleral Service Li	22		Francis de 15 500 Unive					MD 2	20901
ây.	23a. Part1. Enter the disease, or c	omplications that cause	d the death. Do not e						Approximat Interval Bet Onset and I	
Physician	shock, or heart failure. List o Immediate Cause (Final disease or condition	nly one cause on each i	EL ERAN	14 CCUIA	P AP	CADEN	1	- 17	Onset and I	Death
/Medical	resulting in death)	a Due to (or as	s a consequence of):		- 110	CADEN	0			
Examiner	Sequentially list conditions,	b. #	THO.	(CERO	716	VAIC	use			
Examiner or and instrument in and	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	s a consequence of):	7	ICFAI	E				
xecul and al-trar	that initiated events resulting in death) Last	c Due to (or as	a consequence of):		LO KY/J	-				
8760, sate be executed by sician and the burial-transit		d								
687 687 illicate as the										
Box 68 Box 68 Box 100	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregnanc	y		1	te of deliver		Year
ords, P.O. Box 68760, requires that the death certificate be executed even signed by the attending physician and hould be detached for use as the burial-transit	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4 ☐ Pregnant a 9 ☐ Unknown	at time of death 5	Other (specify)					Juy	
, P.O. that the d		s contributing to death 1	but not resulting in the	underlying cause giv	ven in Part I.	23e. Did t	tobacco use cont	ribute to the	cause of d	leath?
Cords, Por w requires that w requires that should be det	HIPEOTE	VSION		0		10	Yes 2□No	3 🗌 Proba	ibly 4	Jnknown
ecord aw requir as been si	CHROME DISEASE,	OBSTR	VCT/4	PUVM	ONSE	24a. Was	an 24b.	Were autop	sy findings	available ause of
I Rec The law ate has b	DISEASE.	HY TO	THIE	01010	1//	perfo 1 ☐ Yes	ormed?	death? 1 🗌 Yes 🗆		
Vital F	25. Was case referred to medical examiner?	Hamilah.				eath (Check only o				
of Vita of Vita Physicien:	1 ☐ Yes 2 ☐ No 27. Mann Death	Hospital: 1 Impat				Home 5 Resi	dence 6 Oth		)	
On O	1 Accident investiga	28a. Date of Inj (Month, Da	ay Year) Injun	Wo	rk? Yes 2 □ No	200. 20001120	now injury coour	.00		
Division of Vital Roll or Attending Physicien: The after death.  Director: After this certificate in the by the funeral director, page	2 Accident Investigate 3 Suicide 6 Could not determine	ot be 28e. Place of In	njury - At home, farm,	street, factory, office	-	28f. Location ( City or To	Street and Numb	er or Rural	Route Num	iber,
Div Div tel or A tel or A	27. Mann Death  1 Natural 5 Pending  2 Accident investige  3 Suicide 6 Could not determine	building, e	tc. (Specify)			City of 10	wn, State)			
To the Hospitel within 24 hours a To the Funeral I completely filled		Physician: To the besi xaminer: On the basis and manner s	of examination and/or							;)
To the To the comple	29b. Signature and title of certifier	1		29c. Licens	se number	-01	29d. Date signe	d (Month, D	Day, Year)	
	I Yellat &	1 beliker	( MI)	De	35	5/ 1	nalou	8	200	5
<u> </u>	30. Name and address of person we Elliott R.	no completed cause of Goldstein,		e, Print) Executiv	e Blvd,	Rockvill	e, Md 2	0852		
Stat Registra	4887 8 0	2005 32. egist	trar's Signatula	parli						

			For State Registrar	State	of Marylar		artment <i>tificate</i>			and Mer		jiene	005	10103	
	Physicia	an	Decedent's Name (First, Midd								Date of Dear Month arch 1	Day	Year	3. Time of Death 2:10 P	1
	/Medic Examin		4a. Facility Name (If not institution	Calvin La			4b. City, To	own, or Le	ocation o		al CII I	_	County of Death		
	Examin	CI	23783 Hurry F	load			Cha	ptic	0			Sa	int Mar	v's	
	Funeral		5. Social Security Number	6. Sex 1(X) M 2□ F	7. Age (In yrs.		If Under 1	Year	If Under 2 Hours	Min.	Date of Birth (Month, Day,	(Year)	CoL	place (State or Foreig	
	Director		215-26-0235	IMM 2LIF		75 <sub>Yrs.</sub>				Ma	arch 2	2,19	29 Distr	ict of Colum	<u>bi</u>
	and w		Usual Residence of Decedent  10a. State 10b. County	,	10c. Ci	ity, Town or La	cation							10d. Inside City Limits	
	Maryl f aho	ь	Maryland Sair	it Mary's		Chapti	20							1 ☐ Yes 2 <b>XX</b> 0	)
	r 28a	irec	10e. Street and Number				10f. Zip C	code			1	0g. Citiz	en of What Cou	intry?	
	th with	Funeral Director	23783 Hurry F	load				2062	1				USA		
	ams 3	ner	11. Marital Status		ecedent Ever in U	J.S. 13. \	Was Decede	nt of Hisp v Cuban,	anic Orig	gin? (Specify , Puerto Rica	Yes or No-	1	4. Race - Amer Black, White		
36	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-f ahow tha Madical Exartativat i ust be indiffed at	by Fu	1 Never Married 2 Ma	If Yes.	s 2 📉 No Give		I□Yes 2		Specify:			,	Specity: Wh		
Ö	hour tural	ed b	3 Widowed 4 Divorce	nt's Education	r Dates:	16a Decer	lent's Usual	Occupation	on			16h Kin	nd of Business/I	ndustry	
7.	n "na	plet	(Specify only highe	est grade complete	e (1-4or 5+)	(Give	kind of work OO NOT use	done dur		t of working		100. 1411		addity	
212	d with giene ar tha	Completed	Elementary/Secondary (0-12)	College	B (1-401 5+)	S	eafood	C1e	rk			Gro	cery		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or Itams 23a or 28a-f ahow any injury or other traumatic event, the Medical Examination will be multilized at once.	Be (	17. Father's Name (First, Middle	Last)				1	8. Mothe	r's Name (F	rst, Middle, I	Maiden S	Sumame)		
yla	ould to Ment Marka Marka	ဥ	Walter Benjam							Ada (	•				
Mar	12 sh h and 7 is m maum		19a. Informant's Name/Relation										Town, State, Zi		
e,	1 and Healt am 2	. 69	Sylvia Marie I  20a. Method of Disposition	acey / W	20b.	Place of Dispo	sition (Name	of		Date			and 206		-
Baltimore,	ages int of t: ff it y or o	- 03	1 ABurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (		om State	cemetery, cren			- 1	March 17, 20	1				
ij	artme ortan injur		21. Signature of Funeral Service		/ Pat	red Hear	. Name and	Address	of Facility	y	275			laryland	+
B	Departing Department on in processing in pro		Muchant	MYM H	Menn	Ma P.	ttingle O. Box	y-Gar 270.	diner Leona	r Funera ardtown.	l Home, Maryla	P.A	0650		
	42		23a. Part1. Enter the disease, o shock, or heart failure. Lis	r complications that only one cause of	at caused the dea	th. Do not ent	er the mode	of dying,	such as	cardiac or re	spiratory arr	est,		Approximate Interval Between	
	Physician .		Immediate Cause (Final disease or condition	A	THEROS	scien	TIL (	AR	Hei	VASCU	LAR	Pys	CASC	Onset and Death	
	/Medical Examiner		resulting in death)		to (or as a conse	quence of):								\	
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8760,	death certificate be executed e attending physician and of for use as the buriat-transit	dicail													
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Вох	death certifica attending ph d for use as t	an/	23b. Was decedent pregnant in the past 12 months?	1⊡Liv	outcome of pregn re birth 2 □ Fet	aldeath 3□	Ectopic pre					2	3d. Date of deliv	very Day Year	
	the at	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		egnant at time of nknown	death 5	Other (spec	cify)						54,	
P.0	requires that the d		Part II. Other significant condit	ions contributing to	o death but not re	sulting in the u	nderlying cau	use given	in Part I.		23e. Did tol	bacco us	se contribute to	the cause of death?	
ds,	w requires that been signed to should be deta	d by	· Acu-	TE PE	NA T	AILUF	2E				1 □ Ye	es 2	]No 3∏Pro	bably 4 Unknown	1
COL	> 40 0	lete	•							į	24a. Was a		24b. Were aut	opsy findings available	3
Re	о <u>г</u> е	ompleted									autops perform	sy med? 2 12 No	prior to co death? 1 \( \sum \subseteq \text{Yes}	ompletion of cause of	
of Vital Record	ician: Th certificate rector, pag	Be C	25. Was case referred to medic examiner?	al				2	26. Place	of Death (C	heck only on				_
) t	ys diib	To I	1 ☐ Yes 2 ☐ No			ER/Outpatier							Other (Speci	ify)	
	ing P	on:	27. Manner of Death 1 ☑Natural 5 ☐ Pend	ng (A	ite of Injury fonth, Day Year)	28b. Time of Injury		c. Injury a Work?			. Describe ho	ow injury	occurred		
Sic	Attanding ir death. ector: After by the fune	icat	3 Suicide 6 □ Could		ace of Injury - At h	nome form etc	M oot factory		s 2 🗆 l		Location (St	treet and	Number or Rui	al Route Number,	_
Division	for A after Direct	Certification:	4 ☐ Homicide deten	mined 200. Fi	ilding, etc. (Spec	ify)	oot, ractory,	Omoo			City or Town	n, State)			
1	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1 Certify	ng Physician: To	the best of my kn	owledge, deatl	occurred at	the time,	, date an	d place, and	due to the c	ause(s) a	and manner as	stated.	
0/	tha Ho nin 24 h tha Fu npletely	ledical	(Check only 2   Medice	I Examiner: On th and π	e basis of examin nanner stated.	ation and/or in	vestigation, i	n my opir	nion, deat	tn occurred a	at the time, d	ate and	place, and due	to the cause(s)	
	To t To t	Σ	29b. Signature and title of certifi	er			29c.	License r	-		2	_	signed (Month	. Day, Year)	
			Mym		MD			$\nu$ s	60	46		2.1	15:05		
			30. Name and address of person				Print)	= X	INTri	1 D.ix	MIS	C \/ 1	JOED	MD 20636	
	Sta	ite	31. Date filed (Month, Day, Year	) 32	2. Angistrar's Sign	ature	# 100 C		30 1 CF	1-10	/ ( )	~ 101	1-02	06,16	_
Ĺ	Regist	-	31. Date filed (Month, Day, Year MAR 1	6 2005	Alex	N A									

		•	For State of State of Registrar	Maryland / Depa	artment of H		_	giene 05	10104
I	Obveriei		Decedent's Name (First, Middle, Last)				2. Date of De Month	Day Y	3. Time of Death
	Physicia /Medic		Mary Virginia Lawrence		,		March	7, 2005	6:15 p M
	Examin	er	4a. Facility Name (If not institution, give street and num	ber)		r Location of Death		4c. County of	
_			9703 Admiralty Drive 5. Social Security Number 6. Sex	. Age (In yrs. last birthday)	Silver If Under 1 Year		8. Date of Bin		gomery  Birthplace (State or Foreign
	Funeral Director		169-32-8570 1□ M 2□XF	65 Yrs.	Months Days	Hours Min.	Nov • 28	Y. Year)	Country) (lassachusetts
	ס		Usual Residence of Decedent						
	arylan show	_	10a. State 10b. County	10c. City, Town or Lo					10d. Inside City Limits
	8e-f	Director	Maryland Montgomery	Silver					1 ☐ Yes 2X(3XNo
	with the		10e. Street and Number 9703 Admiralty Drive		10f. Zip Code 20910	1		10g. Citizen of Wh USA	
	ns 23	Funeral		lent Ever in U.S. 13.	Was Decedent of H		ecify Yes or No		American Indian,
1215-0036	d within 72 hours after death with the Maryland jiene. rr then "neturel", or items 23e or 28e-f show the Madical Exact for mutt be notified at	by	1 Xever Married 2 Married 1 Yes 3 Widowed 4 Divorced Amed For 1 Yes If Yes, Giv	ces? 2 <b>(3</b> No	If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	Specify:	Rican, etc.)	Black,	White, etc. White
, O	72 ho	sted	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occup	ation during most of work	rina	16b. Kind of Busi	
7	nthin ne. hen "	Completed	Elementary/Secondary (0-12) College (1-	4or 5+) life.	DO NOT use retired	a)		Private Social W	Practice/
7	filed within Hygiene.  Other then ent, the Ment		17. Father's Name (First, Middle, Last)	Clini	cal Socia		e (First Middle	Maiden Sumame)	
Maryland	d be f ental I ked o	To Be	Stephen Lawrence				Sulliv		
ary Z	shoul ind Mi mari umeti	H	19a. Informant's Name/Relationship (Type, Print)	ous 150r 19b. Maili	ng Address (Street	and Number or Run	al Route Numbe	er, City or Town, St	ate, Zip Code)
Ž	and 2 alth a 27 is		Mary Daniel Turner, SNDd	eN 1212	Madison	Street, 1	WW, Wash	nington,	DC 20011
ore.	of He		20a. Method of Disposition 1 □ Burial 2 ☑Cremation 3 □ Removal from S	20b. Place of Dispo cemetery, creates	osition (Name of matory or other place	Marc	h 11,	20c. Location - C	ity or Town, State
Ĕ	Rent ment Grant Grant		`4 □ Donation 5 □ Other (Specify)		an Cremator	у 200	05	Alexandr	ia, Virginia
Baltimore,	permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygien Importent: if item 27 is marked other the any injury or other treumetic event, the once.		21. Signature of Poperal Service Licensee	le s	rancis Adgre 00 Univer	s torilyins sity Blvd	Funeral	l Home In ilver Spr	ing, MD 20901
			23a. Part 1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on ea	used the death. Do not en ch line.	ter the mode of dyin	ng, such as cardiac	or respiratory a	rrest,	Approximate Interval Between Onset and Death
	Physician	R III	Immediate Cause (Final disease or condition a. Brai	n Metastasis					1½ Months
	/Medical Examiner			r as a consequence of):					C Mantha
		- L	Sequentially list conditions.	static Breas	t Cancer				6 Months
	nted I Insit	mine	Cause (Disease or injury	st Cancer					2½ Years
<u>_</u>	exection and ial-tra	Examiner	that initiated events resulting in death) Last C. Due to (c	r as a consequence of):					
8/60	The law requires that the death certificate be executed the sbeen signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical	d						
9	artifica ing ph e as th	Med	IF FEMALE:						
ROX	leath certific attending p	Physician/Me	23b. Was decedent pregnant 1 Live bi		□Ectopic pregnancy	,		23d. Date Montl	
0	at the de by the a stached f	ysic	1 ☐ Yes 2 ☐No 4 ☐ Pregna 9 ☐ Unknown 9 ☐ Unkno		Other (specify)				
1	res that tigned by	y Ph	Part II. Other significant conditions contributing to de	ath but not resulting in the u	inderlying cause giv	en in Part I.	23e. Did t	obacco use contrib	ute to the cause of death?
ds	quires n sign	d by					1 🗆 '	Yes 2. Ma No 3	☐ Probably 4 ☐ Unknown
Records,	aw require s been si 2 should b	Completed					24a. Was		ere autopsy findings available
	The lav	mo						rmed? dea	or to completion of cause of ath? ]Yes 2□ No
Vital	iclen: Th certificate rector, pag	Be	25. Was case referred to medical examiner?			26. Place of Deat			
	Physicien: this certificaral director,	2	1 ☐ Yes 2 🔼 No Hospital: 1 ☐ Ir	patient 2 ER/Outpatie		er: 4 Nursing Ho			
<u></u>	ing After une	lon	27. Manner of Death  1 Natural 5 Pending (Month)  2 Accident investigation	f Injury r, Day Year) 28b. Time of Injury	Wor	yat k? Yes 2 ☐ No	280. Describe i	now injury occurred	•
Division of	deat deat ctor: / the	ficat	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place	of Injury - At home, farm, st		100 4 110			or Rural Route Number,
2	after Dire	Certification:	4 Homicide determined buildin	g, etc. (Specify)	, , , , , , , , , , , , , , , , , , , ,		City or Tov	vn, State)	
	To the Hospitei or A within 24 hours after To the Funerel Direct Completely filled in by	edical C	29a. Certifier 1 Certifying Physician: To the control one) 1 Medical Examiner: On the based and mann	sis of examination and/or in	th occurred at the tin evestigation, in my o	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s) and manr date and place, an	ner as stated. d due to the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier		29c. Licens			29d. Date signed (	
	P		I find M Sun	ellons	DS	35996		March 9	, 2005
	(i)		30. Name and address of person who completed cause Linda M. Burrell, M.D.	2730 Unive	ersity Blv	vd,#400,	Wheaton	, MD 2090	)2
	Sta Registr		31. Date filed (Month, Day, Year)  MAR 1 0 2005	gistrar's Signature	who				

Box 68760,
P.0.
Records,
Vital
of
Division

		For State	Type or Print in B State of Maryland	d / Depa		lealth and	Mental Hy	giene	ble.	0105			
		Registrar  1. Decedent's Name (First, Middle, Last		Ce	Tillicate of i	Dealli	2. Date of De	Reg. No.		3. Time of Death			
Physicia /Medic		CATHERINE	C.J. MAR	RCELL	US		March	b x	Year COS	1231AM			
Examin		4a. Facility Name (If not institution, give	th	4c. County									
		Doctors Comm  5. Social Security Number 6. Se		et hirthday)	Lan		S   9 Date of Bird			eorge's			
Funeral Director		230-32-0472	. (Month, Da	y, Year) 9,1931	Coun	lace (State or Foreign try) Jinia							
В		Usual Residence of Decedent											
laryia show	ō	MD Prince	1	0d. Inside City Limits 1XYes 2 □ No									
the h	rect	10e. Street and Number	Jeorge B		tsville			10g. Citizen of V	Vhat Coun	trv?			
th with 23a or	al Di	11523 Old Balt		U.S.A.									
tems	uner	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?		Was Decedent of H	ispanic Origin? (S in, Mexican, Puer	Specify Yes or No to Rican, etc.)		e - Americ				
rs afte	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 22 No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:		Specify	Bl	ack			
72 hou natura ical E	ted	15. Decedent's Edu	16b. Kind of Bu	siness/Inc	lustry								
ithin 7	Completed	(Specify only highest grad	College (1-4or 5+)		dent's Usual Occup kind of work done of DO NOT use retired	f)	irkiig	Howa:		ounty			
filed within 72 hours after death with the Maryland Hygiene. uthar then "natural", or Items 23a or 28a-f show ant, the Medical Evantinar must be notified at	CO	17. Father's Name (First, Middle, Last)	4+	Tea	cher	18. Mother's Na	me (First, Middle,			HOOTS			
ld be lental kad o ic eve	o Be		nes			Franc	, ,		arrans,				
shou and M s mar	-	19a. Informant's Name/Relationship (T)		19b. Maili	ng Address (Street				State, Zip	Code)			
and sealth m 27		James Marcellu				alt. Pi			lle,MD20705				
T its		20a. Method of Disposition	lamoval from State	metery, crei	sition (Name of matory or other place onal Ce	m 3/1	Date L2/05	Laure.					
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If itam 27 is marked other then "natural", or items 23a or 28a-1 show eny injury or other traumatic event, the Medical Evantime must be redified at once.		*4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service icen			2. Name and Addres	i i							
Ped drag	7	Type K. A	nonder?		46 N WA					MD20850			
		23a. Fart1. Enter the disease, or compl shock, or heart failure. List only o	cations that caused the death.						İ	Approximate Interval Between			
Physician		Immediate Cause (Final disease or condition resulting in death)	PLEURAL	EF	FUSION	١				Onset and Death			
/Medical Examiner		resulting in death)	Due to (or as a consequ	ence of):									
	Jer	Sequentially list conditions, if any, leading to immediate											
and I-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events											
e be executed sician and s burial-transit	ai Ex	resulting in death) Last	Due to (or as a consequ	ence of):									
death certificate attending physical death attending physical death at the least the l	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant	23d. Dat	23d. Date of delivery									
a death	sicia	in the past 12 months? 1 □ Yes 2 ☑ No	Mor	Month Day Year									
hat the de od by the a detached	Phy	9 ☐ Unknown  Part II. Other significant conditions con	hacco use contr	co use contribute to the cause of death?									
uires that signed t Id be det	d by	Tall in other organization of		2 No 3 Probably 4 ☑Unknown									
sw require s been si	Completed		an 24b. V	24b. Were autopsy findings available									
The lav	mo:		med?	prior to completion of cause of death?									
ysiclan: The is certificate hadirector, page	Be	25. Was case referred to medical examiner?	faccital.				ath (Check only o	ne)					
Physic r this c	2	1 Yes 2 No	The second secon	R/Outpatier 28b. Time of		4 🗀 i turi sirigi	dome 5 Resid	lence 6 Othe		)			
nding uth. r: Afte e fune	ation	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	Worl	(? Yes 2 □ No							
r Atta er dea racto	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At hor building, etc. (Specify)	ne, farm, str	eet, factory, office		28f. Location (S City or Tow	itreet and Numbern, State)	er or Rural	Route Number,			
oitai o urs aft sral Di		***	_1										
To the Hospital or Attanding Physician: The law requires that the death certificate within 24 hours after death.  To the Funaral Diractor: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Medicai	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my know ner: On the basis of examinati and manner stated.	rledge, deatl on and/or in	n occurred at the time vestigation, in my op	ne, date and place pinion, death occi	e, and due to the our arred at the time, o	ause(s) and ma date and place, a	nner as sta and due to	ited. the cause(s)			
To the vithin To the comple	Me	29b. Signature and title of certifier			29c. License	number		29d. Date signed	(Month, L	Day, Year)			
1		Par G	el.		D00 9	526 3	6	3/6	105	-			
12		30. Name and address of person who co			Print)			^ -		MD			
Sta	0	PATRICIA ESENT	32. Registrar's Signati	nun	ITY HOSP	17ak 8	118 (200D)	UCK RB 1	AHH	am 20706			
Registra	-	MAR 0 9 20	32. pegistrar's Signati	x Ap	النامه								

		1 - For State Registrar		State of	Marylan		artment of F			R	eg. No.2 0 (	15	0	0.6		
Ohuoi		Decedent's Name (Firs	t, Middle, Las	st)						Date of Dear Month	th Day	Yeer	3. Time of D	)eath		
Physi /Med			PU	SHPA	MIN	OCHA				March	6, 200		3:50	$\mathbf{p}_{\mathbf{m}}^{M}$		
Exam		4a. Facility Name (If not in	stitution, give	street and num	ber)		4b. City, Town, or	r Location of	f Death		4c. County	of Deeth				
		Manor Car	re				Potoma	ac			Montg	omery	,			
Funera	al	5. Social Security Number			7. Age (In yrs.		If Under 1 Year Months Days	if Under 2 Hours	Min. 8.	Date of Birth (Month, Day	Year)	9. Birthpl	ace (State or	Foreign		
Directo	r	347-56-953	L	□M 2 <b>X</b> )F	84	Yrs.			1	Dec.7,	1920	India				
pu 🛚		Usual Residence of Dece			10c Cit	v Town or Lo	ocation					110	d. Inside City	r Limita		
aryla sho	5											1,0	1 SarYes 2			
Ba-f	acto		псеош		10	Comac										
with t	D I	10e. Street and Number					10f. Zip Code			1	0g. Citizen of V	Vhat Count	ry?			
s 236	Funeral Director	9239 Potor	пас			_	2085				USA					
er de litem	E C	11. Marital Status		12. Was Dece	ces?	S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Orig an, Mexican,	in? (Specify , Puerto Rica	Yes or No- an, etc.)		e - America k, White, e				
S aft	by F	1 Never Married 2 3 Wildowed 4 D		1 ☐ Yes If Yes, Give Year or Da	9		1 ☐ Yes 2 📉 No	Specify:			Specify	Asia	n			
11 Z 1 3-UU36 within 72 hours after death with the Maryland ene. then *natural*, or items 23e or 28e-f show ite Maulcal Exertirer must be rotilied at	ed		ecedent's Ed			16a Dece	dent's Usual Occup	ation			16b. Kind of Bu	siness/Ind	uetna			
in 72	Completed	(Specify on	y highest gra	de completed)		(Give	kind of work done of DO NOT use retired	during most	of working		TOD. INIII OF BU	1511105551110	ustry			
with the state of	E	Elementary/Secondary 10	(0-12)	College (1-	4or 5+)	н	omemaker	,			Own H	ome				
filed Hygin other		17. Father's Name (First,	Middle, Last)				Omemake I	18. Mother	r's Name (Fi	irst, Middle, I	Maiden Sumam					
Iryland 21215-U should be filed within 72 ho nd Mental Hygiene. marked other than "natur matic event, II te Maulcal	To Be	Prabhu Da	aval L	uthra				Lax	mi Bai	i Luth	ra					
Maryland 21215-UU36 Id 2 should be filed within 72 hours all lith and Mental Hygiene. 27 Is marked other than "natural", or rtraumatic event, Its Madical Exert	-	19a. Informant's Name/R				19b. Mailie	ng Address (Street	and Number	r or Rural Ro	oute Number	City or Town,	State, Zip	Code)			
and 2 and 2 ealth a 127 is		Hemant Mir	nocha/	Son		1514	Mintwood	Dr.,	McLea	an, Va	.,22101					
Dailimore, Marylar permit. Pages 1 and 2 should b Department of Health and Menta Important: If them 27 is marked eny injury or other traumatic e	_	20a. Method of Dispositio				lace of Dispo	sition (Name of matory or other place	20)	Date	1	20c. Location -	City or Tov	vn, State			
Pages nent of nry or o	وا	1 Burial 2 CCrei	mation 3 [	Removal from S	iate				3/9/0	)5	Arling	ton.	Va			
Saltimore, bermit. Pages 1 ar Department of Hea mportant: If Item my injury or other	ė	"4 □ Donation 5 □ Other (Specify) Northern Va. Crematory 3/9/05 Arling  21. Signature of Funeral Service Licensee 22. Name and Address of Facility Arlington Funeral														
n gars	1	+ mar	47	alco	1		901 N. Fa									
death certificate be executed the properties of attending physician and dor use as the burial-transit	I I	cause. Enter Underlying Cause (Dieease or in jury that initiated events resulting in death) Last  Due to (or as a consequence of):											Interval Betwee	eath		
the death certification the attending plant as as the action of a control of the action of the actio	Physiclan/Medl	IF FEMALE: 23b. Was decedent pregi in the past 12 month 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	is?	4□Pregna 9□Unkno	rth 2 ☐ Fetal unt at time of de wn	death 3[ eath 5[	Ectopic pregnancy Other (specify)			23d. Date of delivery Month Day Year						
IS, T	by	Part II. Other significant	conditions c	ontributing to de	N . 9 .		nderlying cause give	en in Part I.	- 1		acco use contr					
necords, he law requires t e has been signe	ompleted	Coronary Artery Disease 10 Yes ?									s 2 Mo	2 No 3 Probably 4 Unknown				
e law r has be	ple l	OSICOPOPOSIS. 24a. Was an autopsy														
- 10 LT	Con	Performed performed									ned?// d					
ysician: The is certificate director, pag	Be (	25. Was case referred to examiner?	medical					26. Place	of Death (C	heck only on	9)		-			
hys his	ျ	1 ☐ Yes 2 ☐ No		Hospital: 1 □ In	patient 2	ER/Outpatier		4 Daturs	sing Home	5 Reside	nce 6 Othe	r (Specify)				
ding Phy h. After thi funeral	6	27. Manner of Death 1 Atural 5 Pending (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occur									w injury occurre	ırred				
UIVISION I or Attending after death. I Director: Afte	ertification:	2 Accident 3 Suicide 6 □	investigation Could not be					Yes 2□N								
or Al	Ę	4 Homicide	determined	286. Place	of Injury - At ho g, etc. <i>(Specif</i> y	ime, farm, str /)	eet, factory, office			Location (St. City or Town	reet and Numbe , State)	er or Rural	Route Numbe	sr,		
pital urs a eral (	O	20- 0-15-						<del></del>								
DIVISION C • Hospital or Attending P • 24 hours after death. • Funeral Director: After t eletely filled in by the funera	edical	29a. Certifier 1 2 (Check only 2 None)	ledical Exan	ysician: To the la niner: On the ba and mann	sis of examinal	tion and/or in	n occurred at the time vestigation, in my of	pinion, death	h occurred a	it the time, da	ate and place, a	ind due to t	he cause(s)			
To the I within 2 To the I	Mec	29b. Signature and title of	certifier	and mann	o. statou.		29c. License	e number		21	9d. Date signed	(Month. D	ev. Year			
F 3 F 8		Maria	Han	MD			Do	052/	15	1.	a		,, . ou.,			
3			*		-4-4		00	0 20	11)	Y	March	8,2	005			
-		30. Name and address of	1		or death (Item	23a) (Type,	29c. License DO	DS1 -	ton	0.	-112	100 /	2.00	- )		
	tate	31. Date filed (Month, Day	y, Year)		gistrar's Signa	ture A	ockuille	rike	1	Kack	J. I. VE	VVId	2080	d		
Regis		MAD	0.9 2	105	Aug a A	4 40	eve									

		1	1 - State RegistraAMEND#5perINE	State of Ma						and M		giene Reg. No.	05	1011	07
			Decedent's Name (First, Middle, Last)	ath	Day Year										
	Physicia /Medic		John R. Manning March 7.											8:40	) A <sup>M</sup>
		Xaminer 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death											County of Dea		
			Shady Grove Advent		e (In yrs. lasi	t hirthday)	If Under	kvil	Le If Under 2	24 Hrs.	8. Date of Bir		ntgome	thplace (State	or Foreign
	Funeral Director		1/3_/8_/15 11	M 2□F	72	Yrs.	Months	Days	Hours	Min.	(Month, Da	y, Year)	C	PA.	or r oronger
	D	Usuel Residence of Decedent													
	anylan show	10a. State 10b. County 10c. City, Town or Location Montgomery Village									10d. Inside City Lin 1 ☐ Yes 2 🔯				
	he Ma	Director	10e. Street and Number 10ft. Zip Code 10g. Citize										on of lathest C		
	with a or 3	Dir	10e. Street and Number 10f. Zip Code 10g. Citizen of What Co												
	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or Items 23a or 28a-f show ent, I're Medical Examiner must be notified at	Funeral		2. Was Decedent	Ever in U.S.	13. V	Vas Deced			gin? (Spe	ecify Yes or No Rican, etc.)		4. Race - Am	erican Indian,	
9	or Iter		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 📉 If Yes, Give	No	1	Yes, spec		n, Mexican Specify:	, Puerto	Rican, etc.)		Black, Whi		
8	ural',	Completed by	3 Widowed 4 Divorced	Year or Dates:			1 1 63	2 <b>A</b> .; 140	эрөспу.				Specify: V	Vhite	
<u>5</u>	"natu	lete	(Specify only highest grade completed) (Give kind of work done during most of working									16b. Kin	d of Business	/Industry	
7	withir ene. than	duic	Elementary/Secondary (0-12) College (1-4or 5+) 5+ Physicist NIST												
5	filled Hygin other	Be C	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	(First, Middle	, Maiden S	Sumame)		
ılar	uld be Menta rrked tic ev	To B	Frank Manning						May	bell	e Wrigh	nt			
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show among injury or other traumatic event, the Medical Examinatinatination once.		19a. Informant's Name/Relationship (Typ				_				i Route Numb				
≥,	and lealth m 27 her tr		Helen T. Manning	(Wife)		9/25 e of Dispos								. 20886	
Ö	Por its		20a. Method of Disposition 1 ☐ Burial 2 🂢 Cremation 3 ☐ Re	emoval from State	cem	etery, crem	natory or o	ther place	,	Mar.	8,		ation - City or		
睛	it. Pa		<ul><li>4 □ Donation 5 □ Other (Specify)</li><li>21. Signature of Funeral Service License</li></ul>		Heti	-			i	2005	Vol Fui		andria	, va.	
Ba	Deperment of the same of the s		Custin E. K	hu										Md. 20	877
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	cations that caused	I the death.									Approxima Interval Be	ite
	Pnysician		Immediate Cause (Final disease or condition		thm	°								Onset and	Death
	/Medical		resulting in death)	Due to (or as										minus	res .
	Examiner	L	Sequentially list conditions, b	hyp	ertens	un								year	-5
	ed isi	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to ( 🌣 📥	a consequer	nce of):									
	xecut and	Examiner	that initiated events cresulting in death) Last	Due to (or as	a consequer	nce of):									
8760,	cate be executed physician and the burial-transit	dicai E													
9	tificate ig phy as the		-	•											
Вох	that the death certific ed by the attending p detached for use as	Physician/Me	23b. Was decedent pregnant	3c. If yes, outcome 1 Live birth			Ectopic pr	regnancy				2	3d. Date of de		
	e dea he att	sicia	in the past 12 months?  1 Yes 2 No	4☐ Pregnant at 9☐ Unknown			Other (sp					,	Month	Day	Year
P.0	requires that the seen signed by th hould be detache	Phy	9 Unknown  Part II, Other significant conditions con	tributing to death h	ut not resulti	na in the ur	derlying c	alice dive	n in Part I		23e Did	obacco us	se contribute t	o the cause of	death?
ds,	Se us	d by	Partin. Other significant conditions con	tributing to death b	at not results	ing in the di	idony ing o	auso givo	41 H 1 4 GATE 1.			Yes 2			Unknown
Records	v require been si	Completed									24a. Was	an	24h Wara a	utopsy findings	available
Re	e lay has	dmo							-		auto perfe	psy ormeat?	prior to death?	completion of	cause of
Vital	10 11	0	25. Was case referred to medical						26. Place	of Death	1 Yes	2/N0	1 Ll Yes	s 2 No	
<u> </u>	y s	lo B	examiner?	ospital: 1 🔲 Inpatie	ent 2 XEP	VOutpatien	t 3 🗆 DC	Othe			me 5 ☐ Res		□Other (Spe	ecify)	
n of	fter fter	T :uc	27. Manner of Death Natural 5 Pending	28a. Date of Inju (Month, Da	y Year) 28	Bb. Time of Injury	2	8c. Injury Work	at		28d. Describe				
Division	Attending it death. ector: After by the fune	Certification:	Thatural 5   Pending   Pen												
Σ	or Att	rtiff	3 Suicide 6 Could not be determined	28e. Place of Inj building, et	ury - At home c. <i>(Specify)</i>	e, farm, stre	et, factory	y, office		4	28f. Location ( City or To	Street and wn, State)	Number or A	lural Route Nun	nber,
ت	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: Atter th completely filled in by the funeral	Ce	29a. Certifier 12 Certifying Phys	ician: To the heet	of my knowle	adde deem	OCCURRED.	at the tim	e date an	d place 1	and due to the	Cause(s)	and manner a	s stated	
	e Hos 24 h e Fun letely	edical	(Check only 2 Medical Examinone)	ner: On the basis of and manner sta	f examination	n and/or inv	estigation	, in my op	inion, dea	th occurr	ed at the time,	date and	place, and du	e to the cause(	s)
	To th within To th compl	Me	29b. Signature and title of certifier	0.				. License		20			-	th, Dey, Year)	
	~ ~		· warm	Snyde	Mi	() t		DS	99:	27		3.	-07-0	5	
	20		30. Name and address of person who co				Print)								
			Dr. Aron Snyder M 31. Date filed (Month, Day, Year)						. Roc	ckvil	lle, Md	. 208	350		
	Sta Registi		MAR 0 9 20	05 Sz. Jegisti	ar's Signatur	A.	whi	9							

RKD			For II.	1 T.	State	f Manyla	and / Dep	artment.	of He	alth a	and M	•		-	ne.	1 0 1	<i></i>	
					23a,27,2	28a-1	per mee	rtificate	-GPL	eath	as ——	2. Date of De	Reg. No	LUU	Ö	0 Top of	08	
	Physicia		1. Decedent's Name (First, Middle, Last) Alan G. Martin										Da	y 2,200	Year	3. Time of 6:45P		
	/Medic Examin		4a. Facility Name (If	not institution, g	ive street and nu	m <i>ber</i> )		4b. City, To	own, or l	ocation o	of Death	MARCH		. County o		0.771	•	
000			6500 RIGG	S ROAD				HYATI						RINCE	GEO]	RGES		
200	Funeral		5. Social Security Nu 577-66-3		Sex 1X M 2□F	7. Age (In ye	rs. last birthday, Yrs.	Months [	Year Days	If Under :	24 Hrs. Min.	8. Date of Bir (Month, Da July 2	rth ay, Year)	0.40	9. Birthp	lace (State or try) ington	r Foreign	
(1)	Director		Usual Residence of			)(	,					July 2	.4, 1	948	wasn	Ington	. DC	
	Maryland -f show	_	10a. State	10b. County		10c.	City, Town or L	ocation							11	0d. Inside Cit		
	8e-f s	ecto	D.C.	N/A		W	ashingt								1X□Yes	2 🗆 No		
	ours after death with the Marylar rel', or Items 23a or 28e-f show Examitier must be notified at	Dir	10e. Street and Number 1320 Randolph Street, N.E. 20017											hat Coun	•			
	death ms 23	era	11. Marital Status	dorph 5	12. Was Dec	edent Ever in	U.S. 13.			panic Orig	gin? (Spe	cify Yes or No Rican, etc.)		ited States 14. Race - American Indian,				
9	or Ite	/ Fur	1X Never Marrie	ed 2 Married	Armed Fo 1 ☐ Yes If Yes, Gir	24 No		If Yes, specify  1 ☐ Yes 2  X		, Mexican Specify:	, Puerto	Rican, etc.)			, White,			
21215-0036	hours urel',	Completed by Funeral Director	3 Widowed		Year or D	ates:										Americ	an	
7	in 72 ho	olete	(Ѕресі	15. Decedent's I fy only highest g	rade completed)		16a. Dece (Give	dent's Usual ( kind of work DO NOT use	Occupat done du retired)	ion I <i>ring</i> mo <i>st</i>	t of worki	ng	16b. K	and of Bus	iness/Inc	lustry		
212	d with giene rr thar	шо	Elementary/Secon	idary (0-12)	College (	1-4or 5+)		cal Do						Medio	cine			
pu	al Hyg d other vent,	Be C	17. Father's Name (	First, Middle, Las	st)	-	<u> </u>			18. Mothe	r's Name	(First, Middle	, Maider	Sumame	)			
yla	2 should be filed within 72 hours after dea and Mental Hygiene. Is markad other than "naturel", or Items 'aumatic event, Ite Modical Examiter m	To	John T.									Brook						
Maryland	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than 'eny injury or other traumatic event, Italy once.		19a. Informant's Na Theresa			ister)						/ Route Numb						
	Healt Healt tem 2 other		20a. Method of Disp		.5011 (5		. Place of Dispe	sition (Name	of			, Wash		on, I ocation - C			7	
Baltimore,	Pages ent of nt: If i		1 X Burial 2 ☐ 1 4 ☐ Donation		Removal from	State	Gate of	-			4/2/	05			-			
alti	mit. I partm porta y inju		21. Signature of Funeral Service Licensee 22. Name and Address of Facility McGuire Funeral Service															
<u> </u>	89 5 8															20012		
			snock, or near	t failure. List ont	mplications that o y one cause on e	caused the de each line.	eath. Do not en	ter the mode of	of dying,	such as	cardiac o	r respiratory a	rrest,			Approximate Interval Betw Onset and D	veen	
	Physician /Medical		disease or condition resulting in death)  Complications of blunt force head injuries													- Ваш		
	Examiner			•	Due to	(or as a cons	equence of):											
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.															
	be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events c. Due to (or as a consequence of):															
760,	be execian a	cal Ex	resulting in death) L	asi	Due to	(or as a cons	equence of):											
687	lys ec				d													
Вох (	requires that the death certifica een signed by the attending ph hould be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy											23d. Date	of delive	ry		
	that the death hed by the atter detached for u	sicia	in the past 12 r	nonths?		nant at time o		⊒Ectopic preg ☐ Other (spec						Mont			ear	
P.O	at the	Phys	9 Li Unknown									20. Didahan 17. 17. 17. 17. 17. 17. 17. 17. 17. 17.						
	signed b	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown						
Sorc	w requir been si should	Completed										-		1				
Rec	The faw ite has b	dmi										24a. Was auto v perfo		pri	or to con ath?	sy findings a opletion of ca	vailable use of	
$\mathbb{M}^{+}$ . $\mathbb{A}_{\mathcal{U},2}\mathbb{A}^{\mathcal{A}}$ sion of Vital Records,	ysicien: The lav is certificate has director, page 2	Be Co	25. Was case referr	ed to medical			<del>-</del>			26 Place	of Death	1 A Yes (Check only o	2 🗆 No	1 [	Yes	2 No		
3	Physicie this cert	ToB	examiner?		Hospital: 1 🗆	Inpatient 2	☐ ER/Outpatie	nt 3 DOA	04			ne 5□Resi		6 □Other	(Specify	)		
0 0	ng Ph fter th ineral		27. Manner of Death	5 Pending	28a. Date (Mon	of Injury th, Day Year)	28b. Time of	f 28c	: Injury a Work?	at	2	8d. Describe	how inju	ry occurred	d			
	Attending r death. ector: Afte	cati	2 Accident	investigation 6 Could not	no Z		6:53	<b>A</b> <sup>M</sup>	1 🗆 Ye	9s 2 <b>X</b>	1	Subject	Ass	sault	ed			
I	after after Direct	Certification:	4 Homicide	determine	Scene	ing, etc. (Spe	t home, farm, st icify)	reet, factory, c	oπice		V	28f. Location ( City or To	wn, State	2700	Mar	tin Lu	ther	
	Hospitel 24 hours a Funerel I tely filled		29a. Certifier	1 Certifying P	hysician: To the	best of my k	nowledge, deat	h occurred at	the time	, date and	d place, a	ing Ave	cause(s)	and man	ner as sta	ated.		
	To the Hospitel or Attending Phwithin 24 hours after death. To the Funerel Director: After thi completely filled in by the funeral	edical	(Check only one)	2 X Medical Exa	iminer: On the b and man	asis of exami ner stated.	ination and/or in	vestigation, in	n my opii	nion, deat	th occurre	ed at the time,	date and	d place, an	d due to	the cause(s)		
	vith To t	Σ	29b. Signature and t	itle of certifier	1/ 1/			29c. L							(Month, L	Day, Year)		
			Yam	K DOU	MXU. M	D			OC	ME ————			MARC	Н 16	,200	5		
			30. Name and addre	ss of person who	Completed caus	se of death (II	, .	111 I	Penn	Str	eet	Baltin	nore	Marr	v1 an	1 2120	1	
	∮ Sta	te	31. Date filed (Monti		8/	legistrar's Sig	mature	ali		~~			ore,	, rigit	утан	4 4140	1	
8:	Registr		M	AR 21	2005	EUR .	N. P											

2 Accident

3 Suicide

29a. Certifier (Check only one)

4 Homicide

29b. Signature and title of certifier

me Now

Be Completed by Funeral Director

J.

Physician /Medical

**Examiner** 

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 Is marked other than "neturel", or Items 23a or 28a-f show any injury or other traumatic event, The Medical Examinar must be partitled at once.

			ndelible lnk. Ensure	-	_	
For	State o	•	partment of Health and	Mental Hygie	ene	10100
State Registrar		C	ertificate of Death	Reg	CUU.ou	10109
. Decedent's Name				2. Date of Death Month	Day Year	3. Time of Death
	Irving John M	cCabe		March	9 200	5 6:30 A <sup>M</sup>
a. Facility Name (If r	not institution, give street and nur	mber)	4b. City, Town, or Location of Dea	th	4c. County of De	
eninsula			Salisbury		Willom	
Social Security Nui	1 <b>№</b> M 2□ F	7. Age (In yrs. last birthda	Months Days Hours Mir	. (Month, Day, Y	ear) C	rthplace (State or Foreig Country)
218-20-44 sual Residence of D	04	79		Nov.3,	925	MD
	10b. County	10c. City, Town or	Location			10d. Inside City Limits
MD	Worcester	Ocean	City			1 X Yes 2 □ No
e. Street and Numb		Occum	10f. Zip Code	10g	. Citizen of What C	Country?
12453 Old	l Bridge Rd.		21842		US	
. Marital Status	12. Was Dece	edent Ever in U.S. 1	3. Was Decedent of Hispanic Origin? (	Specify Yes or No-	14. Race - Am	
1 Never Marrie	d 2 Married Armed Fo	2 ₩ No	If Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 2 ☑ No Specify:	no mican, etc.)	Black, Wh	
3 Widowed 4	Divorced If Yes, Giv	ates:	1 ☐ Yes 2 X No Specify:		Specify: V	mile
	15. Decedent's Education y only highest grade completed)	(G	cedent's Usual Occupation ive kind of work done during most of w	orking 16	b. Kind of Busines	s/Industry
Elementary/Second		1-4or 5+)	e. DO NOT use retired)			
[2	P. A. A. C. (1971)	Owi	ner-Operator		ervice S	tation
. Father's Name (F				me (First, Middle, Ma	iden Sumame)	
	ton J. McCabe		- · · · · · · · · · · · · · · · · · · ·	Adkins		
	ne/Relationship (Type, Print)  McCabe (wife)		ailing Address (Street and Number or F 3 Old Bridge Rd.		*	
a. Method of Dispo		cemetery of	sposition (Name of rematory or other place)	Date 20	c. Location - City o	r Town, State
	Cremation 3 ☐ Removal from 5 ☐ Other (Specify)	State		2-05 E	Berlin, M	arvland
1. Signatore of Fun	Service Licensee		22. Name and Address of Facility T 108 William St., B	he Burbag	e Funera	
3a. Part1. Enter the	disease, or complications hat c	aused the death. Do not	enter the mode of dying, such as cardia			Approximate
nmediate Cause (F		acrime.				Interval Between Onset and Death
			ung cancer			
sease or condition sulting in death)	Due to	(or as a consequence of):	0			2 years
isease or condition esulting in death)	Due to	(or as a consequence of):	0			2 years
esulting in death)  equentially list cond any, leading to imm	ditions, b	(or as a consequence of): (or as a consequence of):	0			2 years
equentially list cond any, leading to imn use. Enter Under	ditions, bbue to (		0			2 years
sulting in death) equentially list condany, leading to immuse. Enter Under	ditions, b		0			2 years
equentially list cond any, leading to immause. Enter Underland	ditions, b	(or as a consequence of):	0			2 years.
ilsease or condition esulting in death)  equentially list con- any, leading to immause. Enter Underlate initiated events assulting in death) La	ditions, b	(or as a consequence of):				2 years
esulting in death)  equentially list concany, leading to immasse. Enter Underfunder in the interest of the immasse. Enter Underfunder in the past 12 m 1 \( \text{Yes} \)	ditions, nediate principle of the program of the pr	(or as a consequence of):  (or as a consequence of):  (come of pregnancy pointh 2   Fetal death lant at time of death	3 Ectopic pregnancy 5 Other (specify)		23d. Date of de Month	2 y cars
equentially list condany, leading to image. Enter Under Laws. Enter Laws	ditions, nediate principle of the program of the pr	(or as a consequence of):  (or as a consequence of):  (come of pregnancy pirth 2   Fetal death pown	3 Dectopic pregnancy 5 Other (specify)	230 Did taba	Month	Day Year
equentially list condany, leading to immause. Enter Underhalls at initiated events esulting in death) La	b. Due to pregnant notes?  23c. If yes, out 1 Live b. Due to 9. Du	(or as a consequence of):  (or as a consequence of):  (come of pregnancy pirth 2   Fetal death pown	3 Dectopic pregnancy 5 Other (specify)	1 - 0	Month	Day Year to the cause of death?
equentially list condany, leading to limburs. Enter Under to list initiated events is sulting in death) La	ditions, nediate principle of the program of the pr	(or as a consequence of):  (or as a consequence of):  (come of pregnancy pirth 2   Fetal death pown	3 Dectopic pregnancy 5 Other (specify)	1 ☐ Yes 24a. Was an	Month  coo use contribute  2 No 3 F	Day Year to the cause of death? Probably 4 □Unknown
equentially list condany, leading to image. Enter Under Laws. Enter Laws	ditions, nediate principle of the program of the pr	(or as a consequence of):  (or as a consequence of):  (come of pregnancy pirth 2   Fetal death pown	3 Dectopic pregnancy 5 Other (specify)	1  Yes  24a. Was an autopsy performe	Month  coo use contribute  2 No 3 F  24b. Were a prior to death?	Day Year to the cause of death? Probably 4 Unknown tutopsy findings available
sulting in death)  aquentially list contany, leading to immuse. Enter Underfuse it initiated events sulting in death) La  FEMALE:  ib. Was decedent pinthe past 12 minthe p	b. Due to support the program of the	(or as a consequence of):  (or as a consequence of):  (come of pregnancy pirth 2   Fetal death pown	3 □Ectopic pregnancy 5 □ Other (specify) e underlying cause given in Part I.	1 Yes  24a. Was an autopsy performe 1 Yes 2	Month  coo use contribute  2 No 3 F  24b. Were a prior to death?	Day Year to the cause of death? Probably 4 Unknown tutopsy findings available
equentially list condany, leading to impuse. Enter Under Lusse. Enter Lusse. Ent	b	(or as a consequence of):  (or as a consequence of):  (come of pregnancy pirth 2   Fetal death pown	3   Ectopic pregnancy 5   Other (specify)   e underlying cause given in Part I.	1  Yes  24a. Was an autopsy performe	Month  2 No 3 Proof to death?  1 Ye	Day Year to the cause of death? Probably 4 Unknown tutopsy findings available completion of cause of

**Physician** /Medical Examiner Be Completed by Physiclan/Medical Examiner To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tran Division of Vital Records, P.O. Box 68760, Medical Certification: To

State Registrar

NATESAN USHA

2057359

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year) March 9/2 2005

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 Pending investigation

6 Could not be determined

1415. S. DIVISION ST egistrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

SALISBURY, MD 21804

			For State Registrar		State o	f Maryla	-	artmen ertificat			and M	ental Hyo	giene			10
	٠	460	1. Decedent's Name (First, M	iddle, Last)								2. Date of Dea Month	ath Day	. V	3. Time	of Death
	Physicia /Medic		DOROTHY	M. M	ILLIGA	N						March		, 2005	023	L1 M
	Examine		4a. Facility Name (If not instit	ution, give s	treet and nu	m <i>ber)</i>		4b. City,	Town, or	Location o	of Death		4c.	County of Deat		
			Memorial H	lospi	tal_				Ea	ston				Ta1		
	Funeral		5. Social Security Number	6. Sex	M 2001F	7. Age (In yrs		) If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birtl (Month, Day	h v, Year)	9. Birth	nplace (Stat untry)	e or Foreign
	Director	}	218-48-5735 Usuel Residence of Deceden		23.	9:	3 Yrs.					July 3	, 19	11   Mar	yland	
	and **	-	10a. State 10b. Cou	inty		10c. C	City, Town or I	ocation							10d. Inside	City Limits
	Mary	ō	MD Do	rches	ter				Hur	lock					1 ( <b>Ā</b> Y	es 2 No
	288 7	Jec.	10e. Street and Number					10f. Zip	Code				10g. Citi	izen of What Co	untry?	
	filed within 72 hours after death with the Maryland Hygiene. Ither than "natural", or Itams 23a or 28a-f show ant, the Marileal Examitrationast bandilled at	Funeral Director	403 Academ	ıy St	reet					21643	3		Uni	ted Sta	tes	
	deati	nera	11. Marital Status		12. Was Dece	edent Ever in I	U.S. 13	. Was Deced	lent of Hi	spanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)	T	14. Race - Ame		
ဖွ	or Its	표	1 Never Married 2		1 ☐ Yes If Yes, Gir	2 🔽 No		1 Yes			i, i dollo i	noun, etc.,		Black, White Specify: W	hite	
gan <b>21215-0036</b>	ural',	d by	3 ☑ Widowed 4 ☐ Divor		Year or D	ates:										
<u>7</u>	nati	Completed	15. Dece (Specify only hi	dent's Edu ghest grade	cation e <i>completed)</i>		16a. Dec (Giv	edent's Usua e <i>kind of wo</i> DO NOT us	k done	ation Ju <i>ring</i> most	t of workin	ig .	16b. Ki	nd of Business/I	ndustry	
gan 2121	withir ane. than	dm	Elementary/Secondary (0-1	2)	College (	1-4or 5+)	me.		iemak				0	wn Home		
	filed with Hygiene Ither than		17. Father's Name (First, Mid	dle, Last)				11011	lellian		r's Name	(First, Middle,				
1.1 an	be d tal	To Be	Otho W. Mc	Willi	ams					Dai		Thompso		,		
Milli aryland	2 should and Menis marka	F	19a. Informant's Name/Relat	ionship (Ty	pe, Print)		19b. Mai	ling Address	(Street a					r Town, State, Z	îp Code)	
⊳ ≥			Warren McWill	iams/	Son		P.0	. Box	92,	Rhode	esda1	e, MD	216.	59		
th Ire,	es 1 and 2 of Health of itam 27 i r othar tre	-	20a. Method of Disposition			20b.	Place of Disp	osition (Nar	ne of ther plac	e)	Da	ate	20c. Lo	ocation - City or	Town, State	
roth	Pages nent of I int: If it		¹¥☐·Burial 2 ☐ Cremati • 4 ☐ Donation 5 ☐ Othe		emoval from		ity-Ŵa				3/20/	05	Hur	lock, Ma	arylan	ıd
Doroth Baltimore,	permit. Pages Department of Important: If i any injury or o	1	21. Signature of Funeral Serv	vice License	• // /	-		22. Name an	d Addres	s of Facility	y 1 II -	DA				
	89889		( Wrest	re/	u.c	Odle		216 N.	Om r Mai	n St.	Fed.	me, PA <del>eralsb</del> u	ıra.	Marvla	nd 21	632
			23a. Part1. Enter the disease shock, or heart failure.	e, or compli List only or	cations that one cause on e	caused the dea each line.	ath. Do not e	nter the mod	e of dyin	g, such as	cardiac or	respiratory an	rest,	,	Approxim Interval E Onset an	ate etween
	Priysician		Immediate Cause (Final disease or condition	- a	Sel	sis								35	Day	C Deam
	/Medical- Examiner		resulting in death)		Due to	or as a conse	equence of):	1.0	P	2.					00	
		<u>_</u>	Sequentially list conditions,	t		(or as a nonse	Cignie	167	nec	tim					Value	3
	ted nsit	nin	Sequentially list conditions, any, leading to introduct cause. Enter Underlying Cause (Disease or injury that initiated events	~	Ene	stea	e re	221	dia	100.10					Men	He
<u>_</u>	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	C	Due to	(or as a conse	quence of):		0 -0)	Coc						-(3
Box 68760,		call			1											
89	tificat ig phy as th			- 1970												
ŏ	eath certific attending p	N/N	IF FEMALE: 23b. Was decedent pregnant	2		tcome of pregr pirth 2 ☐ Fet		□Ectopic pr	eanancy				2	23d. Date of defin	-	
	deat	sicle	in the past 12 months? 1 ☐ Yes 2 ☐ No			nant at time of		Other (sp						Month	Day	Year
P.0	at the de f by the a stached	Physiclan/Med	9 Unknown									T				
	res that igned b	ρλ	Part II. Other significant con	ditions cor	tributing to d	eath but not re Ì	sulting in the	underlying c	ause give	n in Part I.				se contribute to	10.0	
ord	w requir been si should	ted	co or contive	- Cesa	<del>~ 1</del> 9	ulme						1 1	9S 2L	□No 3□Pro	Daoly	Inknown
ec	e law	Completed			7			-				24a. Was a autop	sv	24b. Were aut	opsy finding ompletion of	s available cause of
<u> </u>	: The law cate has	Ö.										perför 1 ☐ Yes	2500	1 Yes	25210	
Vita	ician: Th certificate rector, paç	Be	25. Was case referred to med examiner?	-	lospital:				Othe			(Check only or				
o to	Physic this cral dir	7	1 ☐ Yes 2 € No 27. Manner of Death		, Nyc	Inpatient 2	☐ ER/Outpatie	_	A lour	4 Nu		ne 5 🗌 Resid 8d. Describe h		Other (Spec	ify)	
on	ding h. After funer	tlon	1 ☑Natural 5 ☐ Pe	nding estigation	(Mon	of Injury th, Day Year)	Injury	м	8c. Injury Work	(? Yes 2.⊟N				,		
Division of Vital Records,	or Attandii after death. Diractor: A d in by the fu	Certification:	3 ☐ Suicide 6 ☐ Co	uld not be termined	28e. Place	of Injury - At I	home, farm, s	treet, factory	, office		2	8f. Location (S	treet and	d Number or Ru	ral Route Nu	ım <i>ber</i> ,
Ö	al or A s after il Dirac	Sert	4 Homicide		buildi	ing, etc. (Spec	cify)					City or Tow	n, State,	)		
	api oun	<u>a</u>	29a. Certifier 1 Cert	ifying Phys	sician: To the	best of my kn	nowledge, dea	th occurred	at the tim	e, date and	d place, a	nd due to the o	ause(s)	and manner as place, and due	stated.	v(c)
	tha H hin 24 tha F nplete	ledic	one)		and man	ner stated.	Tation and/or i				in occurre					
	with To T	Σ	29b. Signature and title of cer	ntifier 1	0 -	0 11	2	- 0		number	1.0	,		e signed (Month		
			- Litellinu	VII	renja	mork		7 / 7	0	57	141	/ /	1445	CH 17	200	>
			30. Name and address of per							C.	T''1 .	7.67	0.1	CO1		
	Stat	e	Dr. Lakshim 31. Dale filed (Month, Day, Y	ı Vai e <i>ar)</i> "	dyanat 32. P	han, 2 Registrar's Sign	19 S.	washir	gtor	LSt.	Last	on, MD	216	DUL		
8 1	Registra		MAR	1 8 20	005	Carrie .	13.	6034	1							

			1- For State of Maryland / Department / Department / Departmen	artment of H			iege 0 0 5	10111
			Decedent's Name (First, Middle, Last)			2. Date of Dea	th	3. Time of Death
	Physici		Evelyn Elizabeth Morris			March	15, 200	
	/Medic Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or	r Location of		4c. County of D	
Н	Examin	er	Mink Hill Home	Grason				Anne's
	Funcion		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)			4 Hrs. 9 Date of Birth		Birthplace (State or Foreign
	Funeral Director		217-28-4879 <sup>1□ M 2</sup> 101 Yrs.	Months Days	Hours	Min. (Month, Day Scotember	<sup>Year)</sup> 1903 M	country) aryland
			Usual Residence of Decedent				37 1303 11	ar j rana
	/lanc		10a. State 10b. County 10c. City, Town or Lo	ocation				10d. Inside City Limits
	Man H sh	to	Maryland Queen Anne's Grason	nville				1 ▼ Yes 2 □ No
	28a	Director	10e. Street and Number	10f. Zip Code		1	0g. Citizen of What	Country?
	3a or	□	112 Collier Bood	21638			USA	•
	leath ns 2:	Funeral	112 Collier Road  11. Marital Status 12. Was Decedent Ever in U.S. 13.		ispanic Origi	in? (Specify Yes or No-		merican Indian,
	ter o	ᆵ		If Yes, specify Cuba	n, Mexican,	Puerto Rican, etc.)	Black, W	
ဗ္ဗ	Irs al	by	If Yes, Give 3 ★Widowed 4 □ Divorced Year or Dates:	1□ Yes 2∏ No	Specify:		Specify: Whi	t-o
ğ	tura		15. Decedent's Education 16a. Dece	edent's Usual Occupa	ation		16b. Kind of Busine	
15	in 72	Completed	(Specify only highest grade completed) (Give	kind of work done of DO NOT use retired	durina most i	of working	TOD. TAILS OF DESITE	asinoustry
7	with Bne.	E	Elementary/Secondary (0-12)   College (1-4or 5+)	lerk		7	Marvland (	Government
ס	Hyg Hyg thar ant,		17. Father's Name (First, Middle, Last)	TCLK	18. Mother	's Name (First, Middle, I		30 VELITIBLIE
an	ould be filed within 72 hours after death with the Maryland Mental Hygiene. arked other than "natural", or Itams 23e or 28e-f show atic event, I're Medical Evantinar must be routified at	Be c	Edward Silas Thompson			ry Elizabet		
Maryland 21215-0036	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "natural", or Itams 23e or 28a-f show aumatic event, If a Medical Examiner must be notified at	P		ing Address (Street:		or Rural Route Number		Zin Codo)
<u>8</u>	d2s han 7 Is							
ď	1 an Heal em 2 thar		Marion M. Barton Daughter PO Bo		encrev	ville, Maryl	20c. Location - City	
ō	ges it of in		1 X Burial 2 Cremation 3 Removal from State	matory or other plac	· 1			
altimore,	tmer tant					3/18/2005 (	<i>E</i> ntrevile	e, Maryland
Ba	permit. Pages 1 and 2 should be Department of Health and Menta Important: If itam 27 Is marked any injury or other traumatic events.		21. Signature of Funeral Service Licenses	2. Name and Addres	ss of Facility ral Ho	me, P.A.		
	40 = e a		1 / cust 1 1 1000	2 South Se	econd	Street, Der	nton, Mary	yland 21629
			23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.	ter the mode of dying	g, such as c	ardiac or respiratory arre	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition CARDIO PULLEON	cares ATE	nest	-		Onset and Death
	/Medical		Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate    CARDIO PULLICOU	-				
	Examiner		Sequentially list conditions by Reshing tary	Faile	ne			
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury					
	cuter nd rans	Examiner	that initiated events C.					
ó	an au irial-1	EX	resulting in death) Last Due to (or as a consequence of):					
8760	cate be executed bhysician and the burial-transit	dlcal	d					
9		/led	IE FEAMUE.					
ŏ	leath certific attending p	J.	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □	⊒Ectopic pregnancy			23d. Date of	,
m	dea ne att	SCi	1 Yes 2 No	Other (specify)			Month	Day Year
о. О	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	9 Unknown					
	ss this	by F	Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause give	en in Part I.	23e. Did tob	acco use contribute	to the cause of death?
Records,	w require been sig should b	ed	Advanced Serill Dementia			1 ☐ Ye	s 2 No 3	Probably 4 Unknown
S	s be	Completed				24a. Was ar	24b. Were	autopsy findings available
	The fav	l L				autops:	ned? death	
Vital			25. Was case referred to medical		26 Place	1 ☐ Yes 2 of Death Check onlone		es 2 No
	s certifical	o Be	examiner?  1 Yes 2 No  Hospital:  1 Inpatient 2 ER/Outpatier	nt 3□ DOA Othe				pacify) CARE / to me
Division of	ig Phys ter this neral di	$\vdash$	27. Manner of Death 28a. Date of Injury 28b. Time of		/ at	28d. Describe ho		DACINI CHRE 170 ME
Ö	ding I th. : After s funer	달	1 ☑Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation		k? Yes 2.∐No			
<u> S</u>	Attendi death. ictor: A by the fu	flea	3 Suicide 6 Could not be 28e Place of Injury - At home farm str	reet, factory, office		28f. Location (Str	eet and Number or	Rural Route Number,
5	after Dire	Certification;	4 ☐ Homicide determined building, etc. (Specify)			City or Town	, State)	
	spita lours nera rille		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	th occurred at the tim	e, date and	place, and due to the ca	use(s) and manner	as stated
	e Ho 24 h e Fu letely	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my op	oinion, death	occurred at the time, da	ite and place, and d	ue to the cause(s)
	To the Hospital or Attanding Physician: whithin 24 hours after deals. To the Funeral Director: After this certific completely filled in by the funeral director.	Me	29b. Signature and title of certifier	29c. License	number	29	d. Date signed (Mo	nth, Day, Year)
	->-0		De Country a many	λ>	388	-G	3/16	105
			30. Name and address of person win completed cause of death (Item 23a) (Type,	Print)	40		3/14	
			John C. ARRABAL DR. M.D. 223	Hirla Cti	200+	Chentinta	run III.	0 >11-70
	Sta	e	31. Date filed (Month, Day, Year)  32. Registrar's Signature	A SA DE	- co	-17-400110	, pull	1.61460
	Registr	. 19	30. Name and address of person with completed cause of death (Item 23a) (Type, Tolm C. ARRABAL DR, M.D., 223, 31. Date filed (Month, Day, Year)  MAR 1 8 2005					

			1 - State Registrer	State of Ma	•	partment of Fertificate of		nd Mental Hy	/giene Reg. No.2	05 10112
			Decedent's Name (First, Middle, L.	ast)				2. Date of D	eath	3. Time of Death
н	Physicia		Lawren	re De	slies	Ne	ale	Month 03	13 <sup>Pay</sup> 200	5:50p.M
	/Medic	_	4a. Facility Name (If not institution, gi			4b. City, Town, o		Death	4c. County	of Death
	Examin	er	411 Hollyda			Easto			Ta	albot
					e (In yrs. last birthda			4 Hrs. 8. Date of Bi	irth	Birthplace (State or Foreign Country)
	Funeral Director			1₽M 2□F	Ven	Months Days	Hours	Min. (Month, 2)	7. Year 957	
			Usual Residence of Decedent	_X	<u>5</u> 7 ''s.					Maryland
	land ow		10a. State 10b. County		10c. City, Town or	Location		-		10d. tnside City Limits
	Mary	ō	Md. Talbo	t	East	on				1 □XYes 2 □ No
	188-	ec	10e. Street and Number		L	10f. Zip Code			10g. Citizen of V	What Country?
	death with the Maryland rma 23a or 28a-f show r must be notified at	ᅙ	411 Hollyda	v Street		2160	1		U.S.	•
	a 23	ra l		12. Was Decedent	Ever in 11 C 15			in? (Specify Vec or N	o- 14 Bac	ce - American Indian,
36	in 72 hours efter death with the Marylan "natural", or lieme 23e or 28e-f show ledical Exeminer must be notified at	y Funeral Director	Narital Status     Never Married 2 ☑ Married     Widowed 4 □ Divorced	Armed Forces?  1  Yes 2  If Yes, Give Year or Dates:	No	If Yes, specify Cub		in? (Specify Yes or N , Puerto Ricen, etc.)	Blac	ck, White, etc.
8	hou	큣	15. Decedent's 8		16a Dec	edent's Usual Occur	nation		18h Kind of B	usiness/Industry
<del>7</del>	"na	Completed by	(Specify only highest g	ade completed)	(Gi	edent's Usual Occup re kind of work done DO NOT use retire	during most	of working	100.11.10	a and a sure of the sure of th
12	filed within I Hygiene. other then "rent, Ire Max	Ē	Elementary/Secondary (0-12)	College (1-4or 5	1+)	istant S			Homele	ess Shelter
22	be filed withital Hygiene. d other then	ပိ	17. Father's Name (First, Middle, Las	t)			-	r's Name (First, Middle		
ž	T to D	Be	Thoma		2			Netti	e Gerti	rude Curtis
₹	Mer Mark Mark	ဥ				Nin Address (Canas	A and Mumba	r or Rural Route Numi	has City as Tayer	Chata Zin Carla)
, Maryland 21215-0036	s 1 and 2 should f Heelth and Mer item 27 is marke other traumatic		19a. Informant's Name/Relationship Diane Ne	ale/wife		411 Holl	.yday	St. Eas	ton Md	21601
Baltimore,	Page nent o ant; If ury or		20a. Method of Disposition  1 Burial 2 Cremation 3  4 Donation 5 Other (Special Contents)		20b. Place of Dis cemetery, co Maryla:	position (Name of ematory or other pla nd Veter	an's	March 22, 2005	Chelte	enham Md.
Balt	permit. Departr Imports any inju		21. Signature of Funeral Service Lice	ensee HO		22. Name and Address	ess of Facility y-Gard 270 . T.	, iner Funer eonardtown	al Home	S50
			23a. Part1. Enter the disease, or conshock, or heart faiture. List only	nptications that couses	the deeth. Do not e	nter the mode of dyi	ing, such as	cardiac or respiratory	arrest,	Approximate
			shock, or heart failure. List onl Immediate Cause (Final	y one cause on each M	ne.	- 1				Interval Between Onset and Death
) .	Physician / /Medical		disease or condition resulting in death)	a card		educy ar	west			Latinmp
1	Examiner			Due to (or as	a consequence of):	17	v. 1		_	Q 10
		_	Sequentially list conditions,	b. adver	a consequence of)	mall a	11 113	no conce		I mon ky
	g ≅	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Des to tot de	a echeequation or;			0		
	eath certificate be executed attending physicien and for use as the buriat-transit	ше	that initiated events resulting in death) Last	c						
760,	be execu-		1838 thing in country case	Due to (or as	a consequence of):					
376	ate b nysic he b	icai	•	d						
68	death certifica e attending phi d for use as th	Physician/Medi	AE ECHALE.							
Вох	h cer endir use	Ş	tF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		☐Ectopic pregnand	ev			te of delivery
	A 00 D	icie	in the past 12 months?	4☐Pregnant at		Other (specify)	·,		Mo	onth Day Year
P.0	that the de ed by the detached	hys	9 🗆 Unknown	9□ Unknown						
	The law requires that the site has been signed by the bage 2 should be detached.	by P	Part II. Other significant conditions	contributing to death b	ut not resulting in the	underlying cause gi	ven in Part I.	23e. Did	tobacco use conf	tribute to the cause of death?
qs	uires sigr Id be							\\ \frac{1}{2}	Yes 2□No	3 Probably 4 Unknown
Ö	w requir been si should	ete						24a. Wa	s an 24h	Were autopsy findings available
ě	has has	ηp						auto	opsy	prior to completion of cause of death?
<u> </u>		Completed						1 ☐ Yes		1 ☐ Yes 2 ☐ No
of Vital Records,	Physician: The this certificate ral director, pag	Be (	25. Was case referred to medical examiner?					of Death (Check only	one)	
¥.	g si g	10	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatie	ent 2 ER/Outpat	ent 3 DOA Ot	her: 4□ Nur	rsing Home 5 🗷 es	sidence 6 Oth	ner (Specify)
0 0	ng Ph ter th		27. Manner of Seath  1 ■ Naturat 5 □ Pending	28a. Date of Inju (Month, Da	ry 28b. Time y Year) Injun		iry at ork?	28d. Describe	how injury occur	red
Division	ath. r: Af e fur	atic	2 ☐ Accident investigati	on			]Yes 2 □ N	No		
/is	Attending r death. ector: After by the fune	100	3 Suicide 6 Could not	d 289. Place of Inj	ury - At home, farm,	street, factory, office			(Street and Numb	ber or Rural Route Number,
ă	afte Dir d in t	Certification;	4  Homicide	building, et	с. (Зреспу)			Chy or 10	JWII, State)	
	pspits hours unerel y fille		29a. Certifier Certifying	hysician: To the best	of my knowledge, de	ath occurred at the t	ime, date and	d place, and due to the	e cause(s) and ma	anner as stated.
	To the Hospital or Attending Pr within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical	one)	and manner sta				in occurred at the time		and due to the cause(s)
	To To	2	29b. Signature and title of certifier	.0 A	7		se number	u í		d (Month, Day, Year)
			1 certile	Moroll	<i>w</i> .	$\mathcal{D}_{\cdot}$	3664		03-1	4-2005
	Д		30. Name and address of person wh	completed cause of d	leath (Item 23a) (Typ	e, Print)				- 0.1
			JOYN V	MAST	FLOREA	509	IDIA	JUD AL	EASTO	10916 am
	Sta	te	31. Date filed (Month, Day, Year)	3 Tab.	ar's Signature	berte				
	Registr		MAR 1 6	2005	to the p					
DU	MH 17 Rev 1/20	001	122 1	17						
DH			1							

	•		1 - For Stata Registrar	State of Ma	aryland / Depa <i>Ce</i> :	artment of F <i>rtificate of</i>		ientai Hy	giene	15	10113
	Physici		1. Decedent's Name (First, Middle, La		Lee O'Nea	1		2. Date of De Month	Day	Year	3. Time of Death
	/Medio Examir		4a. Facility Name (If not institution, gir	re street and number)		4b. City, Town, c	or Location of Death	MAN	4c. County	of Death	
	Exami		404 West Washing	ton Street		Had	gerstown			ashin	
	Funeral		5. Social Security Number 6.	Sex 7. Ag	e (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bi			place (State or Foreign ntry)
	Director		218-62-7762 Usual Residence of Decedent	1 🛣 M 2 🗆 F	53 Yrs.	Months Days	Hours Min.	April	16,1951		nsylvania
	yland 10W		10a. State 10b. County		10c. City, Town or Lo	ocation					10d. Inside City Limits
	Mar-field	ţŏ	Maryland Washing	ton		Hage	rstown				1 XYes 2 No
	r 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Cou	ntry?
	15 wit	a D	404 West Washing	ton Street		217	740		U.5	5.A.	
	dea	Funeral	11, Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No	- 14. Rad	e - Americ	can Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other then "naturel", or Items 23a or 28a-f show mith injury or other traumatic event, the Medical Examinal must be notified at ance.	by	1 ☐ Never Married 2 🌠 Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 ☐ I If Yes, Give Year or Dates:	Army	1 ☐ Yes 2 🛣 No		riodii, etc./	Specif	ck, White, y: W.	hite
Ö,	72 ho	Completed	15. Decedent's E		16a. Dece	dent's Usual Occup	pation	<i>i</i>	16b. Kind of B	usiness/In	dustry
2	thin 7	ople.	(Specify only highest gr Elementary/Secondary (0-12)	College (1-4or 5	ife.	DO NOT use retire	during most of work d)	ing			
7	filed wi Hygien other th	Con	12			Counselor			Halfwa	и Но	use
Maryland	be file	Be (	17. Father's Name (First, Middle, Las	")			18. Mother's Name	e (First, Middle			
<u>   </u>	Ment Ment arked	2	Frederick R.	O'Neal, Sr	•		Dorotl	ny R. K	elly		
a	2 sho and Is mu		19a. Informant's Name/Relationship	,			and Number or Run				
	and ealth n 27 ner tr		Frederick R. O'Ne	al, Jr. (B			25/20		hsburg,	Mary	land 21783
altimore,	Pages 1 nent of Hi int: If iter iry or oth		20a. Method of Disposition 1 ☐ Burial 2 【ACremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Speci		20b. Place of Dispo cemetery, crei Smithsbur	natory or other plac	ce) March	2005	20c. Location -		own, State  Maryland
altir	permit. P Departme Importan any injur		21. Signature of Funeral Service Lice		22	2. Name and Addre	ss of Facility	J.L. Da	vis Fune	eral	Home
m	205 20		John Les	· DAVIS						lary1	and 21783
		9	23a Partt. Enter the disease, or con shock, or heart failure. List only	plications that caused one cause on each lin	the death. Do not ent	er the mode of dyir	ng, such as cardiac o	or respiratory a	rrest,		Approximate Interval Between
. 1	Pnysician		Immediate Cause (Final disease or condition	a Non	www have I	Paper in	1000				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequent of):	U	,				
1	Lxammer	70	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence of):	1 TI Th	Hend				
	ted nsit	nin	Cause (Disease or injury		a 5511554 <u>261165</u> 51).						
	s be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):					-	
68760	rificate be executed ng physician and as the burial-transit		l	d							
89	tificate I g physi as the b	Medical		0.							
.O. Box	death cei e attendir	by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)	,		23d. Dai Mo	te of delive	ery Day Year
<u> </u>	that the dened by the and detached f	Ph	Part II. Other significant conditions	contributing to death b	ut not resulting in the u	aderlying cause giv	en in Part I	23e Did t	obacco use cont	ribute to th	ne cause of death?
ds,	signe Id be		• • • • • • • • • • • • • • • • • • •	de dresses		toonying oddoo gir	orrari divi.		_		ably 4 🗆 Unknown
Ö	w require been sig should b	lete		0.0				Odn Minn	045 )	M	- C-
l Records,	The la ate has page 2	Completed							rmed?	were autop prior to con death? 	psy findings available mpletion of cause of
Vital	or Attending Physicien: after death. Director: After this certific in by the funeral director,	Be	25. Was case referred to medical examiner?				26. Place of Death				
	Physic this car	2	1 Yes 2 □ No	Hospital: 1 Inpatie	nt 2 ER/Outpatien	t 3 DOA Oth	er: 4 🗆 Nursing Ho	me 5/10 Resi	dence 6 Oth	er (Specify	y)
Division of	ding PI h. After ti funera		27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injur (Month, Day	Year) 28b. Time of Injury		y at		now injury occurr		
0	uttendii death. ctor: A y the fu	atic	2 Accident investigation	11111 F 19	1	M 1 🗆	Yes 2∭No	ichin le	Haunsho	TTIH	78
Ξ̈	I or Attend after death Director: /	Certification:	3 ☑ Suicide 6 ☐ Could not be determined		ury - At home, farm, str. c. (Specify)	eet, factory, office		City or Tox	Stre a and Numb vn, S ate)		
	itel curs af			3	HOR.	/		404 W.WA	SHST HAL	ersten	. herk
	To the Hospitel o within 24 hours aft To the Funerel Di completely filled in	Medical	29a. Certifier 1 ☐ Certifying PI (Check only one) 1 ☐ Certifying PI (Check only one)	nysician: To the best on niner: On the basis of and manner sta	of my knowledge, death examination and/or in- ited.	n occurred at the ting restigation, in my o	ne, date and place.	and due to the	cause(s) and ha	nner as st	ated
	To th within To th compl	Me	29b. Signature and title of certifier	- 1	$\bigcirc$	29c. License	e number		29d. Date signed	(Month,	Day, Year)
			-H. N. Werk M	1 20011	MONE)	00	111266		mac 1	9 04	
2			30. Name and address of person who	complet carse of de	eath (Item 23a) (Type,		n md	21	742		
	Sta	te	31. Date filed (Month, Day, Year)	32 Registra	ar's Signature	now	wind	ox I	. / 2		
	Registr	- 43	MAR 2 1 20		. It has	ules					

			For	State of Maryla	nd / Depa		alth and Me	•	enns	10111
			1 - State Registrar		Ce	rtificate of De		Reg. M	<del>(</del> 0.	101114
	Physici	an	Decedent's Name (First, Middle, La					2. Date of Death  Month	ay Year	3. Time of Death
	/Media	cal	Ann McGregor Ore  4a. Facility Name (If not institution, giv			4b. City, Town, or Loc		March 07,	2005 lc. County of Deat	2:30 A <sup>M</sup>
	Examir	ner	10005 Kensington			Kensington			Montgome	
	Funeral		5. Social Security Number 6. S	Sex 7. Age (In yrs	s. last birthday)	If Under 1 Year If		8. Date of Birth (Month, Day, Yea		hplace (State or Foreign untry)
L	Director		163-36-1244	1□M 2\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	7.2 Yrs.	Months Days H	dours Min.	08/20/193	2 Mic	higan
	land		Usual Residence of Decedent  10a. State 10b. County	10c. C	City, Town or Lo	ecation				10d. Inside City Limits
	Mary 1 she	ţo	MD Montgom	erv K	ensingt	on				1 X Yes 2 □ No
	th the	Director	10e. Street and Number			10f. Zip Code		10g. (	Citizen of What Co	Luntry?
	23a c	ralD	10005 Kensington	Parkway		20895		U	.S.A.	
	er des	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of Hispa If Yes, specify Cuban, M	nic Origin? (Spec dexican, Puerto R	cify Yes or No- lican, etc.)	14. Race - Ame Black, White	
35	irs aft	by F	1 ☐ Never Married 2 🔯 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates:		1 ☐ Yes 2X No S	Specify:		Specify: Wh	ite
21215-0036	be filed within 72 hours after death with the Maryland tial Hyglene. d other than "natural", or items 23e or 28e-f show event, Its Medical Ext. ill art i ust be nuitled at	ted	15. Decedent's E		16a. Dece	dent's Usual Occupation	n	16b.	Kind of Business/	Industry
7	thin 7	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done durin DO NOT use retired)	ng most of working	9		
	led will her the her the	Co	17 Fabrus Nova (Class Middle Last	5+	Teac		14 11 1 11		ivate Sc	hoo1
anc	d be findal Hed ot	Be c	17. Father's Name (First, Middle, Last,	!			. мотпетs Name Helen Me	(First, Middle, Maide	en Sumame)	
Maryland	2 should be filed w n and Mental Hygie 1s marked other t raumatic event, II.	은	Archie McGregor  19a. Informant's Name/Relationship (	Type, Print)	19b. Maifi	ng Address (Street and			or Town, State, 2	In Code)
S	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury of other traumatic e one.		Richard S. Orens,			Kensington				
Baitimore,	es 1 a of He of Hem Lothe		20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐	20b.		sition (Name of matory or other place)	Da		Location - City or	
Ĕ	Pag ment ant: II		`4 ☐ Donation 5 ☐ Other (Specif	Tuelling al Holli State		e Crematory	03/11	/2005 Bal	Ltimore,	Maryland
Za Za	permit. Depart Import any Inj once.		21. Signature of Furieral Service Licer	ISEE MILE		2. Name and Address of		mple Trib		
_	403 8 8		232 Part 1 Enter the disease or com	all July		040 Rockvil			le, Mary	
	9		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final			er the mode of dying, st	uch as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
, I	Physician /Medical		disease or condition resulting in death)	a. Anal Cance:  Due to (or as a conse						3 Years
	Examiner		Conventingly, list annulities	b	.,,.					
	P	iner	Sequentially list conditions, it any leading to mineral cause. Enter Underlying	Due to (or as a consu	quence of):					
	be executed ician and burial-transit	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conse	aguence of):					
ÇQ,	ate be executed hysician and the burial-transit	ical E	l	d						
ρ	death certificate e attending physi d for use as the			. 0.						
ŏ	death certifica attending phy of for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr		Ectopic pregnancy			23d. Date of deli	
ם ה	e dea the att	sici	in the past 12 months? 1 ☐ Yes 2 🕅 No 9 ☐ Unknown	4☐Pregnant at time of 9☐ Unknown		Other (specify)			Month	Day Year
Ţ.	w requires that the de been signad by the should be detached	Phy	Part II. Other significant conditions of	contributing to death but not re	esulting in the u	nderlying cause given in	Parti	23e. Did tobacco	use contribute to	the cause of death?
as,	requires leen signa hould be	d by	•		<b>-</b>			1 🗆 Yes	77	bably 4 Unknown
COLO	law req as beer 2 shou	Completed						24a. Was an	24b. Were au	topsy findings available
T	و بر ق م	omp						autopsy performed?	death?	ompletion of cause of 2 No
	ician: Th certificate ector, pag	Be C	25. Was case referred to medical examiner?			26.	. Place of Death	1 ☐ Yes 2 ☒ N (Check only one)	10 101	2 10
0 0	hys his	70	1 ☐ Yes 2X No		☐ ER/Outpatien			e 5 💢 Residence		ify)
	ng fter ine	ion:	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work?	28 2 □ No	3d. Describe how inj	ury occurred	
<u>s</u>	Attending r death. actor: After oy the fune	ficat	2 Accident investigation 3 Suicide 6 Could not b	e 28e. Place of Injury - At I	home, farm, str			If. Location (Street a	and Number or Ru	ral Route Number.
5	al or / s after il Dira	Certification:	4 Homicide	building, etc. (Spec	cify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Town, Sta	te)	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Diractor: A completely filled in by the fu		29a. Certifier 1 Certifying Ph	nysician: To the best of my kn niner: On the basis of examin	nowledge, death	occurred at the time, d	date and place, ar	id due to the cause(	s) and manner as	stated.
	the H nin 24 the F nplete	fedical	onej	and manner stated.	iation and/or in					
	vitl con	Σ	29b. Signature and title of certifier	c 50		29c. License nui			ate signed (Month	
	3		30. Name and address of person who	completed cause of death (the	230) (Time	D43083	)	Mar	ch 8, 200	
			George A. Sotos,				#300 - Roy	ckville.	Marvland	20850
	Sta	te	31. Date filed (Month, Day, Year)	90 Desigtante Cian	anturo		, 500, 100		J Zana	
	Registr	ar	MAR 0 9 200	5 American S	6004					

			1 - For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of H		Mental H	ygiene (	)05	10115
		п	1. Decedent's Name (First, Middle, L	ast)				2. Date of I	Death		3. Time of Death
	Physic		Larry R	ichard	Potts			Month March	8, 200	Year	
	/Medi Examir		4a. Facility Name (If not institution, g		10225	4b. City, Town, or	Location of Deat			ounty of Deat	1:58 a.m
	LAGIIII	ici	St. Mary's H	·							
	Funeral				je (In yrs. last birthday		onardtow If Under 24 Hrs			St. Mar	
	Director		269-36-4922	1 TOM 2 TF	63 Yrs.	Months Days	Hours Min.	(Month, I	Day, Year)	Co	hplace (State or Foreignatry)
			Usual Residence of Decedent		03			NOV.23	3, 1941	Ohi	_0
	ylanc 10W		10a. State 10b. County		10c. City, Town or L	ocation					10d. Inside City Limit
	Man -f sh	to	Maryland St.	Mary's		C+ Tm-					1 ☐ Yes 2 N
	the 28e	Director	10e. Street and Number	mary s		St. In:	rgoes		10g Citize	n of What Co	unto/2
	with with		/0110 D + 0	-1- D 1							,
	eath	Funeral	48118 Post 0	12. Was Decedent	Everin IIS 13		584	posifu Voc or t		d Stat	
	ter d	5	1 Never Married 2 Married	Armed Forces?		Was Decedent of Hi If Yes, specify Cuba	n, Mexican, Puer	o Rican, etc.)	10-	Black, White	
36	rs af	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	140	1 ☐ Yes ŽŽNo	Specify:		S	oecify: Wh	ite
21215-0036	be filed within 72 hours after death with the Maryland hat hygiene.  Individual then "natural", or Items 23a or 28e-f show event, the Medical Examiner must be notified at	ed	15. Decedent's		16a Dace	dent's Usual Occupa	tion		105 16-1	of Decision of	1
15	in 72	Completed	(Specify only highest g	rade completed)	(Give	kind of work done of DO NOT use retired.	lurina most of wo	rking	100. Kind	of Business/l	ndustry
7	with ene.	Ę	Elementary/Secondary (0-12)	College (1-4or !	5+)				D 6		
2	e filed within at Hygiene. cother then 'vent, the Me		17. Father's Name (First, Middle, Las	t)		Consultar	1E 18. Mother's Nar	ne (First Midd			tracting
an	ntal ed o	Be						, ,	,	iiiiaiiie)	
2	2 should be and Mental is marked aumatic ev	2	Lewis R. Pot  19a. Informant's Name/Relationship		401.11.11			eora La			
Maryland	permit. Pages 1 and 2 should be Department of Health and Menta Important: If tiem 27 is marked any injury or other traumatic en <u>once</u> .					ng Address (Street a					
	1 and Healt em 2 ther		Shane Potts 20a. Method of Disposition	/ Son	20b. Place of Dispo	Hollister	Street	, Ventu Date			
altimore,	ges For or		1 Burial 2 ☐ Cremation 3	☐Removal from State	cemetery, cre	matory or other place	9)	Date	20c. Loca	tion - City or 1	Town, State
틆	. Pa tmen tant: jury		`4 ☐ Donation 5 ☐ Other (Spec	ify)	Northwood	d Cemetery	3-13	2-2005	Cambr	id e,	Ohio
Ball	Departition Depart		21. Si ung al Solvice Line	noo	2:	2. Name and Addres	s of Facility Br	insfiel	d Fune	ral Ho	me. P.A.
ш	90 E 9 9		Edward N. Brinsi		MUUU52   22	<u> 2955 Holly</u>	wood Roa	ad, Leo	nardto	wn, MD	20650-027
			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused one cause on each li	the death. Do not en	ter the mode of dying	, such as cardiac	or respiratory	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		2.00 1	Ones	1	0			Onset and Death
	/Medical		resulting in death)	a Due to (or as	a consequence of);	regar	···	a c	2		
6	Examiner			/	Tend 1	300	. 5	2011	e: .		
		ĕ	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	à curisequerice ut):	1000	~ <u></u>	1	4		
	uted	Examiner	Cause (Disease or injury that initiated events	. 11	y wall I	201-1.	de	5/	1		
Ć.	execun an an ial-tr	Exa	resulting in death) Last	Due to (or as			16	24	845,56		
8760,	icate be executed physicien and s the burial-transit	dlcal		d Co	w If	Olone	ele				
89	ificat g phy as th	edle									
Вох	nding use	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d	. Date of deliv	uen.
m	leath atte	cia	in the past 12 months?	1 □Live birth 4 □ Pregnant at		Ectopic pregnancy Other (specify)			200	Month	Day Year
o.	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	9 Unknown	9□ Unknown							
٥.	that led b deta	V P	Part II. Other significant conditions	contributing to death b	ut not resulting in the u	nderlying cause give	n in Part I.	23e. Did	tobacco use	contribute to	the cause of death?
Records,	uires signe	d by	11	Den = -	TRANT	Solore	10-	1 [	Yes 21/21	lo 3∏Pro	bably 4 Unknown
Ö	w requir been si should	Completed							21		
ĕ	has has	m			<u> </u>			24a. Wa auto	opsy	prior to co	opsy findings available ompletion of cause of
		S						1 ☐ Yes	formed?	death?	2 No
Vital	ysician: Th	Be	25. Was case referred to medical examiner?	Hamitata			26. Place of Dea				
5	phys this al dir	2	1 ☐ Yes 2 🔼 No	Hospital: 1 1 Inpatie		t 3□ DOA Othe	r: 4 Nursing H	ome 5 Res	idence 6 🗆	Other (Speci	fy)
Ē	ding Ph h. After th funeral	lon	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injui (Month, Day	Year) 28b. Time of Injury	Work'		28d. Describe	how injury or	ccurred	
Division of	tend leath tor: ,	cat	2 Accident investigation 3 Suicide 6 Could not to	ne -			es 2 □No				
	I or Atten after deatl Director: I in by the	Certification;	4 Homicide determined		ury - At home, farm, str c. <i>(Specify)</i>	eet, factory, office		28f. Location City or To	(Street and N own, State)	umber or Run	al Route Number,
	urs a aral [		X								
	To the Hospitel or Attending Physician: within 24 hours attendath: To the Funeral Director: After this certifical completely filled in by the funeral director.	edical		hysician: To the best of miner: On the basis of	Mannation and of in	n occurred at the time	e, date and place, inion, death occur	and due to the	cause(s) and	d manner as s	stated.
	the the mplet	Med		and manner se	géd.						
	To	-	29b. Signature and title of certifier	4//		29c. License			29d. Date si	gned (Month,	Day, Year)
1	PAC		1020	1) ("	Come to	D00327	30		3/9	120	05
	10		30. Jame address o rson who	completed cause of de	eath (Item 23a) (Type,				1	/	
			/ Joseph Colon			oke Squar	e, Ste.	311, Wa	aldorf,	, MD 20	)603
	Sta Registr		31 Date filed (Month, Day New) 1	4 2005 Regis	r's Signature	book)					

			1 - For State Registrer	State of I	Marylar		artmen rtificat			ınd Me		jiene	IIII	011	6
	Physici		Decedent's Name (First, Midd.  Herbert	B.		Port	er				2. Date of Dea Month March		2005 Year	3. Time of 10:32	
	/Medio Examir		4a. Facility Name (If not institution Shady Grove	n, give street and numb				-	Location of	f Death		40	County of Death		P
	Funeral Director		5. Social Security Number 577-28-2656  Usual Residence of Decedent	6. Sex 7. 1 ☑ M 2 ☐ F	Age (In yrs. 82	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	B. Date of Birth (Month, Day Oct. 29	, Year,	9. Birthp Cour 1922 Wash	olace (State of ntry) ningtor	r Foreign
	the Maryland 28a-f show	Director	10a. State 10b. County	rederick	10c. Cit	ty, Town or Lo	amsvi					Oo Ci	tizen of What Cour	0d. Inside Cit	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or Items 23e or 28e-f show miniouty of the result of the show he injury of the traumatic event, the Medical Ener's are must be rediffied at once.	by Funeral Di	2907 Urbana I  11. Marital Status  1 Never Married 2 Mar 3 Widowed 4 Oroccec	12. Was Decede Armed Force 1	s? 2 No			217 lent of Hi cify Cuba		jin? (Spec , Puerto R	ify Yes or No- ican, etc.)	og. O	USA  14. Race - Americ Black, White, Specify: Whi	an Indian, etc.	
Maryland 21215-0036	d within 72 ho giene. sr than "netur The Medical I	Completed		t's Education st grade completed) College (1-40	or 5+)	life. l	kind of woi DO NOT us	rk doné d se retired,	urina most		7		ind of Business/Ind		
and	ild be file lental Hy ked othe Ic event	To Be C	17. Father's Name (First, Middle, Herbert McKir.						18. Mother	r's Name (	First, Middle, I	Maider	Sumame)		
Mary	id 2 shou th and M t7 Is mar traumat		19a. Informant's Name/Relations Audrey L. May						nd Number	r or Rural	Route Number	; City o	or Town, State, Zip		
Baltimore,	Pages 1 an lent of Heal nt: If item 2		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	3 □Removal from Sta	te C	Place of Dispo cemetery, crem rge Wash	sition (Nan natory or o	ne of ther place	e) [	Da March 200!	<sup>te</sup> 9,	20c. L	ocation - City or To	wn, State	
Balti	permit. Departrr Importe eny inju		21. Signature of Funeral Service	Licensee Col	Pe .					ins l	Tuneral	Но	phi, Mar ome Inc or Spring		901
8760,	/Medical Examiner the private of the	lical Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Sever Due to (or Conge Due to (or Inter	e Caro as a conseq stive as a conseq	diomyoruence of):  Heartuence of): al Fibr	athy Fail							Approximate Interval Betw Onset and D	reen
.O. Box 6	The law requires that the death certifica lte has been signed by the attending pi page 2 should be detached for use as i	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcor 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 ☐ Feta t at time of d	Ideath 3	Ectopic pro						23d. Date of delive Month		ear
S, D	w requires that been signed by should be deta	ed by Ph	Part II. Other significant condition Parkinson's		n but not res	ulting in the ur	nderlying ca	ause give	n in Part I.				use contribute to th		
al Record		Completed									24a. Was as autops perform 1 Yes 2	y ned?	death?	npletion of ca	vailable use of
Vita		To Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 ☒ No	Hospital:	ationt 2	ER/Outpatien	3 DO	A Othe			Check only on		6 □Other (Specify	Α.	
Division of 1	Attending Phyer death. ector: After this by the funeral di	ation: T	27. Manner of Death  1 SNatural 5 Pendir 2 Accident investi	28a. Date of li (Month, I		28b. Time of Injury		Bc. Injury Work	at	28	d. Describe ho			9	
Divis	To the Hospitel or Attending I within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ined 286. Place of	Injury - At ho etc. (Specify	ome, farm, stre	eet, factory	, office		28	f. Location (Sta City or Town	reet an , State	nd Number or Rural )	Route Numb	er,
	To the Hospitel or A within 24 hours after To the Funerel Dire completely filled in b	edical	29a. Certifier 1 Certifyir (Check only one)	g Physician: To the be Exeminer: On the basis and manner	s of examina	wledge, death tion and/or inv	occurred a restigation.	at the time in my op	e, date and inion, death	place, an	d due to the ca at the time, da	iuse(s) ate and	and manner as sta place, and due to	ated. the cause(s)	
ļ	To the comp	×	29b. Signature and title of certifie	Gant N	>		29c.	License			29		te signed (Month, L		
	11		30. Name and address of person Vinu Ganti,						l162 nantov	wn, M	D 20874		March 8,	2005	
ľ	Sta Registr	_	31. Date filed (Month, Day, Year)  MAR 10	32-Booi	etrarie Signa										

		1 10430		nd / Department of H		•	e	
,		1 - For State Registrar	orato or manytan	Certificate of		Reg. N	/1115	1011/
0	. i.a	1. Decedent's Name (First, Middle, Las	st)			te of Death	ay Year	3. Time of Death
Physic /Med		CHARLES EUGEN			C	3 1	0 05	12340 "
Exam	iner	4a. Facility Name (If not institution, give	1 11 - 21	4b. City, Town, o	or Location of Death	4	County of Death	,
Funera	al	5. Social Security Number 6. S	ex 7. Age (In yrs.	last birthday) If Under 1 Year Months Days	If Under 24 Hrs. 8. Da	te of Birth onth, Day, Yea	9. Birth	place (State or Foreign intry)
Directo		216 30 1886	M 2□ F 71	Yrs. Months Days		13 19		LAND
and		Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Location				10d. Inside City Limits
death with the Maryland ms 23a or 28a-f show	Į.	MARYLAND ALLEGAN	v FF	ROSTBUG				X Yes 2 No
th the or 28s	Director	10e. Street and Number		10f. Zip Code		10g. C	Citizen of What Cou	intry?
ath wi			1		1532	No	U.S.	iona Indian
ter de	Funerai	11. Marital Status  1  Never Married 2 Married	12. Was Decedent Ever in the Armed Forces?		Hispanic Origin? (Specify Yelan, Mexican, Puerto Rican,	etc.)	Black, White	
ING X IX IS-UUSO  be filed within 72 hours after death with the Marylan ital Hygiene.  d other than "natural", or items 23a or 28a-1 show event, it a Medical Exerting must be notified at	2	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2人 No	Specify:		Specify: W	HITE
72 hc	Completed	15. Decedent's Et (Specify only highest gra		16a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	during most of working	16b.	Kind of Business/Ir	ndustry
withir than	ama	Elementary/Secondary (0-12)	College (1-4or 5+)	LABORER	α,		TEXTII	ĽΕ
d be filed ental Hygic sed other c event, II	B C		)		18. Mother's Name (First,	Middle, Maide	en Sumame)	
aryiar should be nd Menta marked umatic ev	L C				MARY THO		RITCHEY	
Mar 12 sho h and 7 is m		19a. Informant's Name/Relationship (		19b. Mailing Address (Street				p Code)
s 1 and st Health item 27 other tr		CATHERINE RITCHE  20a. Method of Disposition	20b.	Place of Disposition (Name of	Date		D 21532 Location - City or T	own, State
Pages nent of int: If it	:	1 XBurial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specif		cemetery, crematory or other pla FROSTBURG MEMOR		/05 FR	OSTBURG,	MD
그 문문을	- SOUCE	21. Signature of Funeral Service Liger	1	22. Name and Addre	ess of Facility	60	W. MAIN	-
D SOFF	a	1/ Janley	111. Dewer		NERAL HOME, F	·A. FR	OSTBURG,	
		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on each line.		ng, such as cardiac or respi	ratory arrest,		Interval Between Onset and Death
Physiciar /Medica		disease or condition resulting in death)	a. Sepsis  Due to (or as a conse	Syndrone				lodays
Examine	r	Convention lies and distant	b					
12 =	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conse	quence of):				
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e be ex	Cai E		d					
GOTGS, P.O. BOX, 08/19  w requires that the death certificate been signed by the attending physishould be detached for use as the	Pa							
ath cer attendin	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn 1 Live birth 2 Fet	al death 3 Ectopic pregnand	y	:	23d. Date of deliv Month	very Day Year
the de	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of 9 ☐ Unknown	death 5 Other (specify)				
s that ined by	by Ph	Part II. Other significant conditions			ven in Part I. 23		use contribute to	
HECOLOS he law requires has been sign			rebral int	ardren		1 🗆 Yes	2□No 3□Pro	bably 4 Nnknown
lecc law ra nas be	Completed				24	la. Was an autopsy performed?	prior to co	opsy findings available ompletion of cause of
ate Da						Yes 2K		2.00 No
OT VITAL Physician: T this certificate ral director, pa	S S	examiner?	Hospital: 1 Npatient 2	☐ ER/Outpatient 3☐ DOA	26. Place of Death (Checher: 4 Nursing Home 5		6 ∏Other (Speci	fv)
SION OT VITA tending Physician: bath. tor: After this certific the funeral director,	1	1	28a. Date of Injury (Month, Day Year)	28b. Time of linjury 28c. Injury Wo		escribe how in		<i>y</i> ,
SIOF tendir eath. or: Af	catic	1 Natural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not be	n	M 1	Yes 2 No			
DIVISION To the Hospital or Attending within 24 hours after death. To the Funeral Director: Atter	Certification.	4 Homicide determined		nome, farm, street, factory, office ify)		ty or Town, Sta	and Number or Rur ite)	ai Houte Number,
To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	J le	29a. Certifier 12 Certifying Pt		nowledge, death occurred at the t				
he Ho in 24 h he Fu pletely	ledical	(Check only 2 Medicel Examone)	miner: On the basis of examin and manner stated.	ation and/or investigation, in my				
With To t	2	29b. Signature and title of certifier  Workookk	Show MD		se number		oate signed (Month, wich 17,	
		30. Name and address of person who	completed cause of death (to		055325	171		
۲	1	WAR ALCOCK CH	IN 48 Turn	Terrace 1	Frostburg +	10 21	532	
	State	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature				
Regis	strar	MAR 2 4 2003	BOREAN JO	19				

	å.		For State Registrar	State	of Marylar		artmen rtificat				_	giene Reg. No.			
			Decedent's Name (First, Middle,	Last)							2. Date of De	ath	<del>4 0 0 ;</del>	3. Time of	Death 8
	Physicia /Medic		WILLIAM	JOSE	ЕРН	RIDE	ENOUE	}			Month MARCE	Day I 17		7.25	a <sup>M</sup>
	Examin		4a. Facility Name (If not institution,	give street and nu	ımber)		4b. City,	Town, or	Location of	of Death		4c.	County of Dea	th	
			Frederick Mem			for a bringh of con		eder		24 Hrs	2 Data of Die		rederi		C
	Funeral			.Sex 1⊠M 2□F	7. Age (In yrs. 75	. <i>iast birtnd</i> a <i>y)</i> Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da FEB. 3,	n y, Year) 1930	9. BII	thplace (State or ountry) JRMONT , M	
	Director		726-18-0988 Usual Residence of Decedent		/ 3						110,0,		1110	JKMON1, M.	D
	nyland how		10a. State 10b. County		10c. C	ity, Town or Lo	cation							10d. Inside City	
	e Ma	Director	MARYLAND FREDER	RICK		EMMITS								1 📉 Yes	2   No
	with th		10e. Street and Number				10f. Zip	Code	2172	7		•	zen of What C S . A .	ountry?	
	eath v	Funerai	238 DEPAUL ST.		cedent Ever in U	J.S. 13	Was Dece	dent of Hi	2172'		city Yes or No		14. Race - Am	erican Indian,	
	fter d	Fun	1 ☐ Never Married 2 ☑ Marrie	Armed F	orces? 2 □ No ive VODI						cify Yes or No Rican, etc.)		Black, Whi	te, etc.	
5-0036	urs a	by	3 Widowed 4 Divorced	If Yes, G Year or I	ive Dates: KORI	EAN	1 🗆 Yes	2⊠ No	Specify:				Specify:	WHITE	
5-0	be filed within 72 hours after death with the Maryland at Hygiene. A death Hygiene do they than "natural", or items 23a or 28a-f show event, The Moulcal Examiner must be notilised at	Completed	15. Decedent's (Specify only highest	Education grade completed	)	16a. Dece (Give	kind of wo	rk done d	furina mos	t of worki	ng	16b. Ki	nd of Business	/Industry	
2121	within ne. han "	mpi	Elementary/Secondary (0-12)	College	(1-4or 5+)		DO NOT U						SECURIT	v	
N	filed v Hygie other t		9 17. Father's Name (First, Middle, La	ast)		I NI	GHT W	ATCH		er's Name	(First, Middle				
Maryland	should be filed within of Mental Hygiene. marked other than marked other than imatic event, the M	o Be	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		RIDEN	OUR							GRABLE		
J.	shoul nd Me mark	2	19a. Informant's Name/Relationshi	р (Туре, Print)		19b. Maili	ng Address	(Street a	and Numbe	er or Rura	i Route Numb	er, City o	r Town, State,	Zip Code)	
Š	alth a 27 is		JEROME F. RIDEN	OUR/SON		1080	5 TAN	EYTO	WN P	IKE,	EMMITS:	BURG	, MD 21	727	
ore,	of Head		20a. Method of Disposition 1 Deurial 2 X Cremation 3	Pomeyal from	1	Place of Dispo cemetery, crea	osition (Nar matory or c	ne of ther place	θ)	D	ate	20c. Lo	cation - City o	Town, State	
altimore,	Page ment: it ant: it ury o		'4 □Donation 5 □ Other (Spe		SM	ITHSBU	RG CR	EMATO	ORIUM	3/18	3/2005	SMIT	HSBURG	, MD 217	83
Balt	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic evonce.		21. Signature of Funeral Service Li	censee	les		2. Name ar 10 W.			- 510			AL HOME MD. 217	27 <b>-</b> 0427	
			23a. Party Enter the disease, or c shock, or heart failure. List or	omplications that	caused the dea	ith. Do not en	ter the mod	e of dying	g, such as	cardiac o	r respiratory a	rrest,		Approximate Interval Betw	veen
	Physician		Immediale Cause (Final disease or condition	M	1400	ardi	21 -	In	far	cti	Dh			Onset and D	in ste
	/Medical Examiner		resulting in death)	Due to	(or as a conse										
	LAGIIIIIO	-	Sequentially list conditions, if any, leading to immediate	b. Due to	(or as a conse	quence of):									
i/	nsit	nine	Cause (Disease or injury		(	4									
,	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	C. Due to	(or as a conse	quence of):									
8760,	death certificate be executed e attending physician and od for use as the burial-transit		1	d											
68	ng ph	Physician/Medical	IF FEMALE:												
Вох	ath ce ttendi or use	lan/I	23b. Was decedent pregnant in the past 12 months?	1 Live	utcome of pregr birth 2 ☐ Fet	tal death 3	⊒Ectopic p					1	23d. Date of de Month	,	ear
Ö.		ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Preg 9□ Unk	nant at time of nown	death 5	Other (sp	pecify)		-					
P.0	law requires that the deas been signed by the		Part II. Other significent condition	s contributing to	death but not re	sulting in the u	indertying o	ause give	en in Part I	l.	23e. Did 1	obacco u	se contribute	o the cause of de	eath?
ds	uires l signi	d by									10	Yes 2	<b>X</b> No 3 □ F	robably 4 🗆 U	Inknown
00	w requir s been si s should I	oiete									24a. Was		24b. Were a	utopsy findings a	vailable
Re	The lar	Completed									auto perfo 1 ☐ Yes	psy rmed? 2 <b>26</b> No	death?	completion of ca s 2□ No	use or
of Vital Records,	iiclan: The lav certificaté*has rector, page 2	Be C	25. Was case referred to medical examiner?						26. Place	e of Death	(Check only				
× ×	Physician: this certific ral director,	To	1 ☐ Yes 2 No			ER/Outpatie			4 🗆 140				6 □Other (Sp	ecify)	
n c	ding P h. After t funera	on:	27. Manner of Death 1 ✓ Natural 5 ☐ Pending	(Mo	e of Injury onth, Day Year)	28b. Time o	of M	28c. Injury Work	/at k? Yes 2□		28d. Describe	how injur	y occurred		
Sic	Attanding r death. actor: After by the fune	icat	2 ☐ Accident investigated inve	ot be I also Bloc	e of Injury - At	home form et			165 2		28f Location /	Street an	d Number or F	Rural Route Numb	her
Division	or Attan efter deatl Diractor:	Certification;	4 Homicide determin	ned buil	ding, etc. (Spec	cify)	reet, lactor	y, ornoe			City or To	wn, State	)		
	To the Hospital or Attanding Physician: within 24 hours effer death.  To tha Funeral Diractor: After this certific completely filled in by the funeral director.	edicai C		Physician: To the											
	o the o tha omple	Mec	29b. Signature and title of certifier	and ma	Stated.		29	c. License	e number			29d. Da	te signed (Mor	th, Day, Year)	
)	⊢s⊢ŏ		Michael	Ler	ner			r a	(61	9		M~	rch 1	7,200	5
	H		30. Name and address of person w		use of death (Ite	om 23a) (Type	Print)							21707	
ľ	Sta Registi		31. Date file (Mosth, Day, Year)		Registrar's Sign			الر ا				- **	<i>)</i> · · · · · ·	-1,0	

Physician /Medical	Grace Conklin Rechen	Month March	0.6. 2005 Year 8:56 A.M
Examine	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
	Holy Cross Hospital	Silver Spring  (i) If Under 1 Year   If Under 24 Hrs. 8, Date of E	Montgomery
Funeral Director	5. Social Security Number 080-03-0765  6. Sex 1 M 2 F 7. Age (In yrs. last birthday 85 Yrs.	Months Days Hours Min. (Month, I	Birth Day, Year) 9. Birthplace (State or Foreign Country) New York
and	Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or I	ocation	10d. Inside City Limits
Maryl Fed a	Maryland Montgomery Kensingt	con	1 XYes 2 ☐ No
h the or 28a roll	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
23a c	11113 Dewey Road	20895	United States
paritimities in Marylainia 212.13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or phar traumatic avant. If a Maryland Examination and once.  To Be Completed by Europea Director	3 ¼Widowed 4 □ Divorced   If Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (Specify Yes or I If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:	14. Race - American Indian, Black, White, etc.  Specify: White
72 ho	15. Decedent's Education (Specify only highest grade completed) (Giv	edent's Usual Occupation re kind of work done during most of working DO NOT use retired)	16b. Kind of Business/Industry
i within 72 houlene.	Elementary/Secondary (0-12) College (1-4or 5+) 5+ Lit	DO NOT use retired)  prarian	Library
Hygie ant.	47 Fabrida Nama (Final Middle Land)	18. Mother's Name (First, Midd	lle, Maiden Sumame)
vuid be file Mental Hy srked oth atic avant		Katherine Elf	leda Huntington
nd 2 shor lith and h 27 is ma r trauma	19a. Informant's Name/Relationship (Type, Print) 19b. Mai	ling Address (Street and Number or Rural Route Num   3 Dewey Road, Kensington	
Deficiency of the moortant: Pages 1 a Department of Her mportant: If item any injury or other once.	20a. Method of Disposition  1  Burial 2  Cremation 3  Removal from State  4  Donation 5 Other (Specify)	ematory or other place) March / 1. University 2005	20c. Location - City or Town, State Washington, D.C.
Till Partme sortan	TIENT CAT	Center  22. Name and Address of Facility Columbia	Mortuary Services, Inc
D ed me a	( Sure Serle	P.O. Box 58007	Washington, D.C. 20037
THE .	23a. Part I. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac or respiratory	arrest, Approximate Interval Between Onset and Death
Physician	Immediate Cause (Final disease or condition resulting in death)	Infaction	Orisot and Dodan
/Medical Examiner	Due to (or as a consequence of):	1	
	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury		
executed in and ital-transit	Cause (Disease or injury that initiated events  c.		
DC, De exe cian a ourial-			
ificate be ex g physician as the buria	d		
e death cert he attendin ned for use	9 Unknown	□Ectopic pregnancy □ Other (specify)	23d. Date of delivery  Month Day Year
wrequires that the been signed by it should be detach		underlying cause given in Part I. 23e. Die	d tobacco use contribute to the cause of death?
quires the sum of the		1	Yes 2 No 3 Probably 4 Donknown
The law requires to the has been signed age 2 should be a considered by		24a. W	as an 24b. Were autopsy findings available prior to completion of cause of
		pe 1 ☐ Yes	rformed? death?
vician ician certifi ractor	25. Was case referred to medical examiner?	26. Place of Death (Check ont	
ding Phys	To tes 20 No To Inpatient 20 EP/Outpati	of 28c. Injury at 28d. Describ	e how injury occurred
r Attending Figure 1 death. Trector: Affer a funer of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the funer of the function of the function of the funer of the function of the function of t	1 Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	M 1 Yes 2 No	
DIVISION C pital or Attanding P ours after death. leral Director: After filled in by the funers	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, so building, etc. (Specify)	street, factory, office 28f. Location City or 1	(Street and Number or Rural Route Number, rown, State)
Hospi 24 hou Funer etely fill		ath occurred at the time, date and place, and due to the investigation, in my opinion, death occurred at the time.	ne cause(s) and manner as stated. e, date and place, and due to the cause(s)
within To the compl		29c. License number	29d. Date signed (Month, Day, Year)
40	1 / my y Mus	D41624	316105
	30. Name and address of person who completed cause of death (Item 23a) (Type G. Patrick Murphy, M.D. 1500 Fore	est Glen Road, Silver Sp	ring, MD 20910
State Registra	31. Date filed (Month, Day, Year)  MAR 0 9 2005  32. Reistrar's Signature	lperti	

		1	For State Registrar	State of Ma	aryland / De	epartment Certificate				jiene <sub>eg. N</sub> 2 0 0	5	101	20
			Decedent's Name (First, Middle, Last)						2. Date of Dea Month	th Day	Year	3. Time o	of Death
	Physicia		Dennis Basi	.1	Richards	3				7, 2005	1 dai	8:30	a <sup>M</sup>
-	/Medic Examin		4a. Facility Name (If not institution, give	street and number)			wn, or Location			4c. County			
			10919 Horde Stre				Wheaton	l der 24 Hrs.			ntgor		
	Funeral Director		5. Social Security Number 6. Security Number 1216-60-4310	7. Ag	e (In yrs. last birth 52 Yr	Months	Days Hour		8. Date of Birth (Month, Day Nov 7	, Year) , 1952	Coui	place (State ntry) hingto	-
	pu *	-	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location					- T	10d. Inside C	City Limits
	Aaryla I sho	ō		tgomery	Whe	aton						1 🗌 Yes	s 2½∏ No
	28a-	Director	10e. Street and Number		1	10f. Zip C	ode			I0g. Citizen of V	Vhat Cou	ntry?	
	h with		10919 Horde Stre	et		20	0902			USA			
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23e or 28e-f show many injury or other traumatic event, the Medical Exact is at mantitle motified at ance.	by Funeral	11. Marital Status  1 ☒ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1  Yes 2  If Yes, Give Year or Dates:		13. Was Decede If Yes, specif	y Cuban, Mexi	can, Puerto	ecify Yes or No- Rican, etc.)	Blac	e - Americk, White,		
21215-0036	in 72 hou n "natural	Completed I	15. Decedent's Edu (Specify only highest grad	e completed)		Decedent's Usual Give kind of work life. DO NOT use	done during n	nost of work	ing	16b. Kind of Bu	ısiness/In	ndustry	
212	iene.	E O	Elementary/Secondary (0-12)	College (1-4or		Computer	Operat	or		Gener	al E	lectri	.C
ğ	ai Hyg	BeC	17. Father's Name (First, Middle, Last)				18. Mo		e (First, Middle.				
Maryland	Menta Menta arked	10	John Minor Richa						aret Ge				•
Jar	and ris m	- 11	19a. Informant's Name/Relationship (T)			Mailing Address ( L810 New							20833
e, l	1 and Health Bm 27 ther t		Joseph Richards/	brother	20b. Place of I	Disposition (Name	of .		Date	20c. Location -			.0033
nor	ages in of or		N Burial 2 ☐ Cremation 3 ☐ F  '4 ☐ Donation 5 ☐ Other (Specify)			, crematory or oth Hill Cei		i	h 11,	C467	a 14	1	
Baltimore,	permit. P Depertme Importan any injur.		21. Signature of Funeral Service Licens			22. Name and Francis 500 Uni	Address of Fa J. Col versity	icility Llins	Funeral , W, Si	Suitland Home I lver Sp	nc		
	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition	ne cause on each I	othe death. Do no ine. Myocardia	ot enter the mode	of dying, such					Approxima Interval Be Onset and 5 Minu	ate etween d Death
	/Medical Examiner		resulting in death)		a consequence of								
Н	Examine	<u>.</u>	Sequentially list conditions, if any, leading to immediate		ry Artery		e					years	
	ted nsit	Examiner	Cause (Disease or injury	222 10 (21 11		,							
Ć,	cate be executed oblysician and the burial-transit	Exal	that initiated events resulting in death) Last	Due to (or a	a consequence of	f):							
8760,	ate be physicia the bur		(	d									
Box 6	aath certifii attending f for use as	sician/Medical	in the past 12 months?  1 ☐ Yes 2 ☐ No		e of pregnancy 2 DFetal death at time of death	3 ☐ Ectopic pre					te of delive	very Day	Year
P.0	± ≥ 3	Physi	9 ☐ Unknown  Part II. Other significant conditions co		but not resulting in	the underlying ca	usa given in P	art I	23e, Did to	obacco use cont	tribute to	the cause of	death?
	sign d be	þ	Diabetes Mellity		Dut not resulting in	the underlying ou	030 given in 1					bably 4	
Vital Records,	he law e has b age 2 sl	ompleted						<del></del>	24a. Was autop perfo 1 \( \text{Yes} \)	rmed?	prior to death?	topsy finding ompletion of 2 \( \text{No}	s available cause of
ita		BeC	25. Was case referred to medical examiner?					lace of Dea	th (Check only o	ne)			
of V	Physicien: this certific ral director,	To	1 ☐ Yes 2X No	Hospital: 1 ☐ Inpat				Nursing H	ome 5% Resid			ufy)	
o u		lon:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of In (Month, D	ay Year) 28b. T	ime of 28 ijury M	ic. Injury at Work? 1 ☐ Yes	2 TNo	28d. Describe I	now injury occur	red		
Division	Attener deat	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of li	njury - At home, far etc. <i>(Specify)</i>				28f. Location (3 City or Tox	Street and Numb vn, State)	per or Ru	ral Route Nu	imber,
	Hospitel or 24 hours afte Funerel Die tely filled in		29a. Certifier 1⊠ Certifying Ph	ysician: To the bes	t of my knowledge	death occurred a	at the time dat	e and place	and due to the	cause(s) and ma	anner as	stated.	
	Hos Fur fely	edical	(Check only 2 Medical Exam	iner: On the basis and manners	of examination and	Vor investigation.	in my opinion,	death occu	rred at the time,	date and place,	and due	to the cause	(s)
	within 2 To the complet	Me	29b. Signature and title of certifier	N		29c.	License numl			29d. Date signe			
	12		▶ Whath	Skinen	N		D20400	!		Ma	ırch	8, 20	U 5
	12		30. Name and address of person who				T.T 1	-m 14D	20006				
			Mark D. Rosen, 31. Date filed (Month, Day, Year)		11 Ferrar		, wneat	UM, NO.	20300				
	St Regist	ate trar	MAR 0 9 20	105 Kings	trar's Signature	sperie							

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				Otate of W	arylana /	Certificate	of Death		Reg. No.	05   0   2
			1. Decedent's Name (First, Middle,					2. Dete of De Month		3. Time of Death
-	Physicia /Medic		BELLE RENERT					March 5	, 2005	7:00 PM
نفر	Examin		4a Fecility Neme (If not institution, g				4b. City, Town, or			
-			Genesis Knollv  5. Social Security Number 6	rood Manor	ge (In yrs. lest bi	rthday) if Under 1			Anne A	
	Funeral Director		043-34-2221		1	Yrs. Months [	Deys Hours Min.	March S	h y, Year) 3, 1914	Poland
	pu ,		Usuel Residence of Decedent  10a. State 10b. County	,	10c. City, Tov	m or Location				10d. Inside City Limits
	faryle hov	ò								XXYes 2 □ No
	the N	Director	Maryland   Anne An 10e. Street end Number	undel	Severn	a Park	ode		10g. Citizen of W	/het Country?
	h with	<u>a</u>	513 Hodges Lane			211	46	ī	Jnited S	tates
	r deat	Funeral	11. Merital Status	12. Was Decedent Armed Forces?	Ever in U,S.		t of Hispanic Origin? (S Cuban, Mexican, Puer			e - American Indian, k, White, etc.
21215-0020	parmit. Peges 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "naturel", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examinar must be notified at page.	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ . If Yes, Give XX Year or Dates:		1□Yes 2□			Specify	White
5	natu	Completed by	15. Decedent's (Specify only highest)	Educetion rede completed)	166	Give kind of work	occupetion fone during most of wa retired)	orking	16b. Kind of Bu	siness/Industry
121	within 9ne. then	d m	Elementary/Secondary (0-12)	College (1-4or	5+)	erical	eureay		Insuran	ce
	filed withi Hygiene. other than	Be Co	17. Fether's Neme (First, Middle, La	st)			18. Mother's Na	me (First, Middle,	Maiden Sumam	е)
/lar	should be to and Mentel I marked or umatic eve	To B	Louis Pinkus				Fannie	Yaffe		
Maryland	2 sho end is is me		19a. informent's Name/Relationship	(Type, Print)			treet and Number or R			
	Health tem 27 is other tre		Temma Schaller - 20a. Method of Disposition	Daughter	51	3 Hodges	Lane, Seven	rna Park,		146 City or Town, State
Ö	Peges nent of P ant: If its ury or o		1 X Burial 2 ☐ Cremation 3			of Disposition (Name ery, crematory or other est Cemet		03-09-05		
Baltimore,	parmit. Pege Department of Important: If any injury or phos.	1	4 ☐ Donation 5 ☐ Other (Spe 21. Signature of Funeral Service Lice							ral Home, Inc.
B	parmit Depart Import any in		▶ alay	Dame	اله	11800 Ne	w Hampshire	e Ave Si.	Lver Spr	ing MD 20904
	Ol distant		23a. Pert1. Enter the disease, ar co shock, or heart failure. List	mulications that cause by one ceuse on eech li	d the death. Do ine.	not enter the mode	f dying, such as cardia	ic or respiratory ai	rrest,	Approximate Interval Between Onset and Death
1	Physician /Medical		Immediate Ceuse (Final	CE	TOFRO	OVASECT	LAR DIS	11.45		VISACS
4	Examiner		disease or condition resulting in death)	е		consequence of):	one or	16436		10.1.01
	B is	lner		b						
	tificate be executed g physician end es the burial-transit	Examiner	Sequentially list conditions, if eny, leading to immediate		Due to (or as e	consequence of):				
68760,	siciar siciar e bun	edical	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events	C	Due to (or as e	consequence of):				
	The law requiras thet tha daath certificate be executed ate hes been signed by the attending physician end page 2 should be detached for use es the bunal-transit	/Med	resulting in death) Last	d						
Вох	aath oert attendin d for use	Physician/M	Pert II. Other significant conditions	contributing to death h	out not resulting	in the underlying cau	se given in Pert I	23b. Did	lobacco use con	tribute to the cause of death?
P.O.	as thet tha daz igned by the a be detached f	hys	ren ii. Odier significant conditions	contributing to death b	out not resulting	iii (iie dildeliyiiig cad	so given an react.		Yes 2 No	3 ☐ Probably 4 ☑ Unknown
	as the	by P								
of Vital Records,	v require been si should	Completed						24a. Was perfo	en eutopsy rmed?	24b. Were eutopsy findings available prior to completion of cause of deeth?
æ	he law e hes age 2	d Lo						10	Yes 2 <b>∕</b> No	1 ☐ Yes 2 ☐ No
ita		Be C	25. Wes cese referred to medical				26. Plece of De	eath (Check only o		
<b>5</b>	G is	2	examiner? 1 ☐ Yes 2 🔀 No	Hospitel: 1  Inpati				Home 5 ☐ Resid		
n c	aft a		27. Manner of Death 1 ☑Naturel 5 ☐ Pending	28e. Date of Inju (Month, De	ary 28b.	Time of 28d Injury M	Injury et Work? 1 ☐ Yes 2 ☐ No	28d. Describe	how injury occurr	ed
Division	or Attending after death. Director: Afte I in by the fune	flcat	2 Accident investige 3 Suicide 6 Could no	be goo Blood of In	iury - At home, f	arm, street, factory, o				er or Rural Route Number,
Θį	afor a after i Dire	Certification:	4 ☐ Homicide determine	building, el	c. (Specify)	•		City or To	vn, Stete)	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completaly filled in by the fi	edical	29a. Certifier (Check only one) 2 Medical Ex	Physician: To the best aminer: On the basis o and menner st	of examination e	e, death occurred at nd/or investigation, ir	the time, date end plac my opinion, death occ	e, end due to the curred at the time,	ceuse(s) and ma date and place, a	nner as stated. and due to the ceuse(s)
	Vithin To the	Z E	29b. Signature and title of certifier	[ 00		29c. I	icense number		29d. Date signed	(Month, Day, Year)
	J		10m ('c	WALLA	up	u)	031136		MARCH	18,2005
			30. Name and address of person when R2 AN C. U	o completed cause of completed CACE	death (Item 23a)	(Type, Print)	LILBRID	ERI)	BALTIMO	ORE, MID 21236
	Sta Registr		31. Dete filed (Month, Day, Year)  MAR 1 0	2005 32. Sgisti	re's Signature	Aparte		)		1 (Month, Day, Year)  1 8, 2005  OCE, Mily 2(23)

			1 - For State Registrar	State of Ma		partment of Fertificate of		_	giene Reg. No. 0 0	5 101	22
-	Physici /Medio		1. Decedent's Name (First, Middle, La PAWL, ItEN	VRY. SC	COTT			2. Date of De Month	Day	Year 2.	of Death
	Examir Funeral		Social Security Number     6.	T HOSPIT	(In yrs. last birthda	Cumb	r Location of Death Color of Death If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da Jul 12,		9. Birthplace (State	te or Foreign
	Director		215-12-2562  Usual Residence of Decedent  10a, State 10b, County	1× 20 1 8	4 Yrs.			Jul 12,	1920	Country) MD	City Limits
	death with the Maryland ms 23e or 28e-f show r must be twiffed at	ector	FL Indian	River	* '	Beach			10g. Citizen of W	1 □ Y	es 3/1 No
	th with 23a or	al Dir	919 Island Club S	guare			32960		US		
21215-0036	hours after deat turel', or Items ?	by Funeral Director	11. Marital Status  1  Never Married   2  Married 3  Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Dyes 2 DNo		B. Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	lispanic Origin? (Spann, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race Blace Specify.	e - American Indian, k, White, etc.	,
15-0	"ne"	letec	15. Decedent's E (Specify only highest gr		16a. Dec	edent's Usual Occup we kind of work done of DO NOT use retired	ation during most of work	ing	16b. Kind of Bu	siness/Industry	
212	d withir giene. ir than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	-) ( .	wner/Oper			Scott Be	autv	
pu	a file II Hyg otha	Be C	17. Father's Name (First, Middle, Last	)			18. Mother's Name	(First, Middle,	Maiden Surnam		
Maryland	should by ord Menta marked metic events	70	Holly E. Scott	T. Dist	T		Susan				
	s 1 and 2 should if Health and Mer item 27 is marke other treumetic	9	19a. Informant's Name/Relationship Mamie Scott	wife	919	Bisland Clu	ub Square	Vero		State, Zip Code) FL 329	60
Baltimore,	Page nent o int: If		20a. Method of Disposition  1			position <i>(Name of</i> rematory or other place emorial Park	ce)	3/22/2005	Cumbe	City or Town, State <b>rland</b>	MD
Balti	permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Service Lies	nsee AAA	1	22. Name and Addre Scarpell 108 Viro	ss of Facility Ii Funeral Ho ginia Avenue		land MD 1	21502	
8760, 7	Certificate be executed did by Sician and American and Sice as the purial-transit see as the pur	Ical Examiner	23a. Part 1. Inter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	).	of Liver		_		Approximinterval E	Between
O. Box 6	death e atter	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti	Fetal death 3	□Ectopic pregnancy □ Other (specify)	,		23d. Date Mon	of delivery th Day	Year
ds, P	law requires that the de as baen signad by the a 2 should be detached t		Part II. Other significant conditions	contributing to death but	not resulting in the	underlying cause give	en in Part I.		-	bute to the cause o	of death?
of Vital Records,	The ate h	Completed by	5/P Mechanical	Aortic Vo	lve Pro	sthesis		24a. Was a autop: perfor 1 🗆 Yes	med? de	lere autopsy finding for to completion of eath?	s available cause of
Vit	Physicien: this certific ral director,	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 Inpatient	t 2 □ ER/Outpati	ent 3 DOA Othe	26. Place of Death				
n of	ng Phys ftar this ineral dii	P-14	27. Manner of Death	28a. Date of Injury (Month, Day	The second second	of 28c. Injury	4 🗆 Nursing Hor		ow injury occurre		
Division	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Diractor: After th completely filled in by the funeral	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	n 280 Place of Injur	y - At home, farm, s		Yes 2 □No	28f. Location (S City or Tow		r or Rural Route Nu	ımber,
_	To the Hospital within 24 hours a To the Funeral I completely filled	edical Ce	29a. Certifier (Check only one) 1 Certifying Pl	nysician: To the best of miner: On the basis of each manner state	examination and/or	ath occurred at the time	ne, date and place, a pinion, death occurre	and due to the c	ause(s) and man ate and place, ar	ner as stated. nd due to the cause	ı(s)
	To the within To the comp	Me	29b. Signature and little of certifier	0 12		29c. License	number	2	9d. Date signed	(Month, Day, Year)	
7	i /	1	30. Name and address of person who	completed cause of de-	ath (Item 23a) (Tues		1720		2/ ///	2003	
_	16			Memorial	Hospita	al Cur	rberlan	d, w	> 2150	5	
П	Sta Registr		31. Date filed (Month, Day, Year)  MAR 2 1 201	2. Registrar	's Signature	els)					

			1 - State Registrar	State of Marylar		partment of I certificate of			iene og. No. 005	10123
ı	Physicia	200	1. Decedent's Name (First, Middle, Las	it)				2. Date of Deal	h Day Ye	3. Time of Death
	/Medic		Laura	Rita	S	ciubba		March	15, 2005	915am <sup>™</sup>
	Examin	er	4a. Facility Name (If not institution, give Citizens Nursing				or Location of Death ederick		4c. County of E	
	Funeval		5. Social Security Number 6. So		last birthd	ay) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		Birthplace (State or Foreign Country)
	Funeral Director			□M 20XF 92	2 Yrs	Months Days	Hours Min.	Dec 25	1912	Ohio
	pu >		Usual Residence of Decedent  10a. State 10b. County	10c Ci	ty, Town or	r Location				10d. Inside City Limits
	faryla shov	ō	Maryland Frederi	.ck	Frede	rick				1 XYes 2 No
	28a-1	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of Wha	Country?
	death with the Maryland ms 23a or 28a-f show Linual be notified at		1900 Rosemont Av	enue			21702		U.S.A	•
	death	Funerai	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	I.S. 1	3. Was Decedent of If Yes, specify Cub	Hispanic Origin? (Sp	ecify Yes or No- Rican, etc.)		American Indian, Vhite, etc.
30	filed within 72 hours after death with the Marylan Hygiene ther than "naturel", or Items 23a or 28a-f show ther than "naturel" is must be natified at	by Fu	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐XNo If Yes, Give		1 ☐ Yes 2 🛣 No		, , , , , , , , , , , , , , , , , , , ,	Specify:	White
9500-612	ture!		15. Decedent's Ed	Year or Dates:	16a. De	ecedent's Usual Occu	pation		16b. Kind of Busine	
دا2 2	hin 72 an "na Media	Completed	(Specify only highest gra		(G	ive kind of work done  e. DO NOT use retire	during most of work d)	ing		
7	od with	Com	9		Dre	ess Maker	,			rment Company
חם	9 E D S	Be	17. Father's Name (First, Middle, Last) Leo		Scuil	bbo	18. Mother's Name			eschine
Maryland	2 shoutd be and Ment is markadamatic e	မ	19a, Informant's Name/Relationship (1	Type Print)		ailing Address (Stree				
<u>8</u>	D = 1 = 1		Mr. George Rago	** *		3 Pump Hou				
စ်	s 1 and f Health item 27 other t		20a. Method of Disposition	20b.	Place of Di	sposition (Name of crematory or other pla	1		20c. Location - City	
Ē	Page nent o int: If		1 ☐ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify	Removal from State St	• Ray	mond's Cer	netery Ma	r 19, 20	005, Bronz	, New York
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature of Funeral Service Ucon	моо.	706	22. Name and Addr	ess of Facility & Basford Church St	P.A. Fu	ıneral Ho	me MD 21701
г			23a. Part1. Enter the disease, or compshock, or heart failure. List only	olications that caused the dea	th. Do not	enter the mode of dy	ng, such as cardiac	reet, From the contract of the	ederick,	MD 21701 Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Cereto	Desero	2)		Onset and Death		
	/Medical Examiner		resulting in death)	Due to (or as a consec	quence of):					
	Examine		Sequentially list conditions,	b	auence of):					
/	nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury	Due to (or as a conser	querice or).					
'n	execu n and ial-tra	Examiner	that initiated events resulting in death) Last	Due to (or as a consec	quence of):					
8/PC	icate be executed physician and s the burial-transit	cal	(	d						
٥	certifica nding ph usa as th	ed	1F FEMALE:							1
X O D	res that the death certificate be executed igned by the attending physician and be detached for usa as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn 1 Live birth 2 Fet	al death	3 Ectopic pregnance	Ey .		23d. Date of Month	delivery ' Day Year
	he de the a	ysic	1 ☐ Yes 2 No 9 ☐ Unknown	4 □ Pregnant at time of e 9 □ Unknown	ceatn	5 ☐ Other (specify) _				
Į.	requires that the aen signed by th hould be detache	by Ph	Part II. Other significant conditions of	ontributing to death but not re-	sulting in th	e underlying cause g	ven in Part I.	23e. Did tot	pacco use contribut	e to the cause of death?
ecords,	w requires baen sign should be					<u>-</u>		1 □ Ye	s 2 <b>X</b> No 3□	Probably 4 Unknown
ပ္သ	> 0 0	ompleted						24a. Was a autops	n 24b. Were	autopsy findings available
r	The ata h page	Com						perforr	red? deati	to completion of cause of 1? Yes 2 No
Vital	ysicien: Th is certificata director, pag	Be (	25. Was case referred to medical examiner?	M In-It			26. Place of Deat			
0	sic di	10	1 Yes 2 10	Hospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpa 28b. Tim	tient 3 DOA			ence 6 Other (5	Specify)
	ding h. After funer	tion	1 Natural 5 ☐ Pending	(Month, Day Year)	Inju	ry Wo	rk? ]Yes 2 □ No	200. Describe no	ow injury occurred	
UIVISION	Atten r daat ector:	ifica	3 Suicide 6 Could not be	28e. Place of Injury - At h				28f. Location (St	reet and Number o	Rural Route Number,
5	s afte	Certification:	4 Homicide	building, etc. (Speci	ty)			City or Town	i, State)	
	To the Hospital or Attending PI within 24 hours after death. To the Funerel Director: After the completely filled in by the funeral.	edical (	(Check only 2 Medical Exam	ysician: To the best of my kn niner: On the basis of examin						
	the hin 24 tha F	Med	29b. Signature and Little of certifier	and manner stated.			se number		9d. Date signed (M	``
	T M I		A L N	- Police		77-	1397,	_	3/1cl	D &
			30. Name and address of person who	completed cause of death (Ite	m 23a) (Ty	pe, Print)	-///		11.16	/_>
	8	ļ, i	Robert L. Kaufma	nn, M.N., 300	West	Ninth Str	eet, Fred	erick, M	Maryland 2	21701
	Sta Registr		31. Date filed (Month, Day, Year) MAR 2 4 2005	32. Registrar's Sign	ature					
					-					

	(ID and	2	For State	State of M		d / Dep		of Hea	Ith and M	lental Hy	gieņe	egible.	10124
	(10 FIVI	1)	Registrar  1. Decedent's Name (First, Middle,	Last)			Sitincate	UI DE	alli	2. Date of De	Reg. No.		3. Time of Death
	Physicia		Robert Owen							March	13 <sup>Day</sup>	2005	6:10 AM
	/Medic Examin		4a. Facility Name (If not institution,		)		4b. City, Tov	wn, or Loc	ation of Death			ounty of Death	
	ZAGIIIII	٠.	Genesis Healtl	nCare - Th	ne Pi	ines		Eas	ton			Talbo	t
	Funeral				ge (In yrs.	last birthda	y) If Under 1 Y Months D		Under 24 Hrs.	8. Date of Birt	h v Year)	Q Birth	place (State or Foreign
	Director		072-18-0324	M 2□F	84	Yrs.	WIGHTIS	ays III	ours with.	11-08	-192	0 Balc	lwin,NY
	and *		Usual Residence of Decedent  10a. State 10b. County		10c, Cit	y, Town or	Location						10d. Inside City Limits
	Manyl f eho	0	Md Talbo	+			haels						1 □ Yes X□ No
	28a-	rect	10e. Street and Number		DC.	MIC	10f. Zip Co	ode			10g, Citize	n of What Cou	ntry?
	72 hours after death with the Maryland naturel', or thems 23e or 28e-f ehow alsal Executer roust be notified at	by Funeral Director	24019 Porters	Creek La	ne		216				USZ		
	death	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.	.S. 13	I. Was Decedent If Yes, specify	t of Hispan	nic Origin? (Spe	city Yes or No	. 14.	Race - Ameri	
9	after or ite	F	1 Never Married Marrie	1 Types 2 If Yes, Give		v	1 ☐ Yes 2X		exican, Puerto pecify:	Hican, etc.)		Black, White, Dec <i>ify:</i> Whi	
93	urel',	d b	3 Widowed 4 Divorced	Year or Dates:			105 24	1140 36	ecny.		Sp	Deciry: VVIII	
21215-0036	natu alica	Completed	15. Decedent's (Specify only highest	Education grade completed)		16a. Dec	edent's Usual O re kind of work o . DO NOT use r	ccupation one during	g most of worki	ng	16b. Kind	of Business/Ir	ndustry
5	withir ene. then	dmc	Elementary/Secondary (0-12)	College (1-4or	5+)						Grumn	nan	
۵ ک	filed Hygi other	ပိ	12 years 17. Father's Name (First, Middle, L.	years years		aer	onauti			(First, Middle,	Maiden Su	ımame)	
th land	ld be ental ked c	To Be	Fred Brower					V	ira Ho	man			
Smith Maryland	shou ind M mar	۲	19a. Informant's Name/Relationshi			19b. Ma	iling Address (SI	treet and N	Number or Rura	I Route Numbe	or, City or T	own, State, Zij	<sup>Code</sup> 663
	and 2 alth a 127 is		Maureen Tall	ing Smith	(wi	fe)	24019	Port	ers Cr	eek L	n. St	. Mic	haels,Md
rrt	of He of He roth		20a. Method of Disposition	Domewal from State	20b. P	lace of Disi	position (Name of	of		ate		tion - City or T	
Rober	Pag ment ent: I ury o		1 ☐ Burial 2 🙀 Cremation 3 ☐ Other (Specific Control of Control	ecify)	Ca	pito.	l Crema	ator	y 3-14	,2005	Dove	er, De	
Robert Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or items 23e or 28a-f show any injury or other traumatic event. It e Medical Exertinat be notified at once.		21. Signature of Funeral Service Li	censee	1		22. Name and A R. Cari	ddress of	Facility Hurle	v Fund	aral	Homo	DC
	20 = e a		R. Carr	el His	M		P.O. Bo						
			23a. Part1. Enter the disease, or o shock, or heart failure. List o	omplications that caused nly one cause on each li	d the death in <i>e</i> .	n. Do not e	nter the mode of	fdying, su	ch as cardiac d	r respiratory ar	rest,	, ma.	Approxi e Interval Between Onset and Death
	Prysician		Immediate Cause (Final disease or condition resulting in death)	-a. Inev	mon	iA							/ Lelle
	/Medical Examiner		roodiling in accumy	Due to (or as	a consequ	uence of):							
		r.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequ	uence of):							
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated events										
ó	le be executed ysicien and e burial-transit	Exa	resulting in death) Last	Due to (or as	a consequ	uence of):							
1760,	nte be nysicie ne bu	icai	,	d									
39	ng ph	Med	IF FEMALE:										
õ	ath ce Itendi	an/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1⊟Live birth	2 Fetal	death 3	□Ectopic pregn	ancy			23d	. Date of delive	•
O.	w requires that the death certificate been signed by the attending phys should be detached for use as the	by Physician/Medi	1 Yes 2 No	4□Pregnant at 9□ Unknown	t time of de	eath 5	Other (specify	y)				Month	Day Year
Α.	hat the ad by detac	Ph	Part II. Other significant condition	s contributing to death h	nut not resu	ulting in the	underlying caus	e civen in	Part I	23a Did to	hacco use	contribute to t	he cause of death?
ds,	signe d be	d by	Emphysema		HOW	- 11	Comes -	ار	ost		es 2 🗆 N		pabiv 4 Munknown
Ö	v requ	ete	7	· · · · · · · · · · · · · · · · · · ·					013	-			
Division of Vital Records, P.O. Box 68	ne fav has ge 2	Completed	Lhanation							24a. Was a autop perfor	sy	prior to co death?	psy findings available mpletion of cause of
a	n: Th	ပိ	25. Was case referred to medical							1 ☐ Yes	2 No	1 ☐ Yes	2□ No
S	/sicle s cert directe	To Be	examiner?	Hospital:	ent 2 □ I	ER/Outpatie	ent 3 DOA			(Check only or ne 5 ☐ Resid		Other (Case)	
ō	g Phy er this	H ii	27. Manner of Death	28a. Date of Inju (Month, Da		28b. Time		Injury at Work?		28d. Describe h			y)
<u>o</u>	nding ath. r: Aft	atio	Datural 5 ☐ Pending 2 ☐ Accident investiga		y rear)	Injury		Work?	2 🗆 No				
<u>×</u>	r Atte er de recto by th	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		ury - At ho	me, farm, s	treet, factory, of	fice	2	28f. Location (S City or Tow	treet and N	lumber or Rura	I Route Number,
	ital o									_			
	To the Hospital or Attending Physicien: The law requires that the death certificat within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	edical	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the best kaminer: On the basis o	f examinat	wledge, dea tion and/or i	th occurred at the nvestigation, in r	ne time, da my opinion	ite and place, a n, death occurre	and due to the co	ause(s) and late and pla	d manner as s	tated. o the cause(s)
	the ithin 2 of the omple	Mec	29b. Signature and title of certifier	and manner sta	ated.		29c. Lic	cense num	nber	2	9d. Date si	igned (Month,	Dav. Year)
	F 3 F 3		1 M H	my my	2	$\sim$		)41	81 L		3/1	4/00	,,
1	\		30. me ind address of power w	ho completed cause of d	leath (Item	23a) (Tvne	Print)	_   2	. 0		21,	11,7	
K	1411K)		K.A (	Nr o re	M	5	55 Cm	hur	of Dr	150	58V2	W.	2/60/
	Stat		31. Date filed (Month, Day, Year)		ar's Signat	ture	Post	)			-		
	Registra		MAR 15	2005	20 1								
DH	HMH 17 Rev 1/20	01	-										

		1 - For State Registrer	State	of Marylar				lealth and I Death	Mental ⊦	lygien Reg. N		C	10125
		Decedent's Name (First, Middle	, Last)						2. Date of	Death			3. Time of Death
Physicia	an	Cynthia Lynn	Spak						March		ay 2, 2	Year 2005	12:08p.m.
/Medic		4a. Fecility Name (If not institution		umber)		4b. City	, Town, or	Location of Deat			c. County		12.00р.ш.
Examin	er	20445 Falling				T.o.	onard	ltown			St	Mary	t <sub>c</sub>
		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)		er 1 Year	If Under 24 Hrs	8. Date of	Birth			lace (State or Foreign
Funeral Director		219-72-4035	1 □ M 2 <b>X</b> F		8 Yrs.	Months	Days	Hours Min.	Mar.	Day, Year		Mary	
		Usuel Residence of Decedent							TICLE .	<i></i>	751	IICILY	
land wo		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation						1	0d. Inside City Limits
Man,	to	Maryland St.	Mary's	T.o	onardt	านา							1 ☐ Yes 2 📉 No
the 28a	Director	10e. Street and Number	riary 5	110	onarac		ip Code			10g. C	itizen of V	Vhat Cour	ntry?
with Sa or	0	20445 Falling	Pines I	ane		21	0650			1	U.S.A		
be filed within 72 hours after death with the Maryland trail Hygiene. It will the Maryland to the than "natural", or items 23s or 28s-f ehow event, the Madical Examinating the malified at	Funerai	11. Marital Status		cedent Ever in U	J.S. 13. V	Vas Dece	edent of H	ispanic Origin? (S	pecify Yes or	-	14. Rac	e - Americ	can Indian,
ter d	'n.	1 Never Married 2 Marri	Armed I	Forces?	11	Yes, sp	ecify Cuba	in, Mexican, Puèr	to Rican, etc.)		Blac	k, White,	etc.
irs at	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, C Year or	Sive	1	☐ Yes	<b>2</b> € No	Specify:			Specify	Whi	te
2 hou		15. Decedent	's Education		16a. Deced	ient's Us	ual Occupa	ation		16b.	Kind of Bu		
in 72 in 72 in a "n	Completed	(Specify only highes	t grade completed		(Give	kind of w	rork done d use retired	during most of wo	rking				
with Bne than	E C	Elementary/Secondary (0-12)	2	(1-4or 5+)	Sai	les/	Servi	.ce			Compu	ter	
Hygi Hygi Sther	Ö	17. Father's Name (First, Middle,						18. Mother's Nai	ne (First, Mide				
d be antal	on .	Lavon Eldon	Schmucker	<b>,</b>			i	Vathor	ine L	ouice	s - Sh	arro	
should ind Men marke umatic	2	19a, Informant's Name/Relations			19b. Mailin	n Addres	ss (Street	and Number or Ri					
C1 (0 -= 65				1									
1 and 1 and 1 ealth 3 m 27 ther tr		Michael M. Spal	K / Husba		ZU445 Place of Dispo			Pines L	Date Le		Location -		ryland 2065 own, State
Pages 1 and of He		1 X Burial 2 Cremation	3 Removal from		cemetery, cren	natory or	other plac	1		2001		O., O	
Pa men tant:		'4 □Donation 5 □Other (S)	2	Sa	int Jar				-18–05				ark, MD
permit. Departimporti		21. Signature of uneral Service	Licensee					ss of Facility Br					
3 88 8 8			field, J					79 Leona			ylan	d 206	650-0279
		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	t caused the dea	th. Do not ente	er the mo	de of dyin	g, such as cardia	c or respirator	y arrest,			Approximate Interval Between
Physician		Immediate Cause (Final		netasta	tii T	3100	it Ca	W(t/					Onset and Death
/Medical		disease or condition resulting in death)	a	o (or as a conse		w en	.11						2 years
Examiner				0 (01 43 4 001130	4401100 017.								
	P.	Sequentially list conditions, if any, leading to immediate	b. Due t	o (or as a conse	quence of):								
led Isit	Examiner	cause. Enter Underlying Cause (Disease or injury	<										
xecur and Il-trai	xar	that initiated events resulting in death) Last	c	o (or as a conse	quence of):								
cate be executed physician and the burial-transit	aE												
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ling p	Me	IF FEMALE:	220 15 100 0	outcome of pregn	2001						201.0	. ( 4.1)	
thend trend	an/	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2 Fet	aldeath 3□		pregnancy	,			23d. Dai	e of deliventh	ory Day Year
he al	sici	1 ☐ Yes 2 ☐ No	4∐Pre 9□Uni	gnant at time of	death 5∟	Other (	specify)			-			
by the	Physician/Me	9 Unknown							00. 0			-1	
ires that the death certific signed by the attending p d be detached for use as	by	Part II. Other significant condition	ons contributing to	death but not re	sulting in the ur	nderlying	cause give	en in Part I.					ne cause of death?
an signal									1	□ Yes j	2LINO	3 ☐ Prob	ably 4 Unknown
s bee	Completed								24a. W		24b. \	Were auto	psy findings available
he la e ha age 2	Ĕ								pe	itopsy erformed?		death?	mpletion of cause of
n: T flicati or, pa	o C	25. Was case referred to medical						26. Place of De	1 Ye		10	162	22 110
sicia certi	00	examiner?	Hospital:	71	☐ ER/Outpatien	t 3 🗆 🖸	Oth	40	dome 5		6 □Oth	or /Specif	i.l
this ral d	<u>۲</u>	27. Mannes of Death			28b. Time of				28d. Descrii				77
Jing After fune	ion	1 ☑Natural 5 ☐ Pendin	9	e of Injury onth, Day Year)	Injury	М	28c. Injur	k? Yes 2 □No					
ttsnc death tor: the	Certification;	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could I	not be	ce of Injury - At h	nomo form etr				28f Locatio	n /Street a	and Numb	er or Rura	I Route Number,
or A	#	4 ☐ Homicide determ	ined 200. Pu	Iding, etc. (Spec	ify)	eet, lacto	ny, onice			Town, Sta		0, 0, 7,0,0	
To the Hoepital or Attsnding Physician: The law requires that the death certification 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as		<b>V</b>					4 4 2	4-7	<u> </u>	L			
t hour rune	edical	(Check only 2 Medical	ng Physicien: To t Examiner: On the	basis of examin	owledge, death ation and/or in	n occurre vestigatio	or at the tinon, in my o	ne, date and place pinion, death occ	e, and due to t urred at the tin	ne cause( ne, date ar	s) and ma nd place,	inner as s and due to	tated. the cause(s)
the F the F	led.	one)	and ma	anner stated.									
With To T	Σ	29b. Signature and title of certifie	1				9c. Licens			290. D	ate signe	i (Month,	Day, Year)
		1 620					DSC	9890			31	17	105
		30. Name and address of person	who completed ca	use of death (Ite	m 23a) (Type,	Print)	,	0	. 11				
J.		Aurdeen S. Chi	rabra, n	ni) a	4035 71	nee	Noter	Road	Holly	W00.	d, 1	MD	20636
Sta	ite	31. Date filed (Month, Day, Year)		Registrar's Sign	ature				9				
Registr		MAD 1 A	200		4 1	- M							

			For State	State	of Mary	land / Del	artmen			and M		giene ()	05	10	126
		÷	Registrar  1. Decedent's Name (First, Middle,	Last)			, in out	<u> </u>			2. Date of Dea	ith		3. Tim	e of Death
	Physici	an			Conn						Month March	Day 20	Year 05	7.0	0 a.m.
	/Medic		Rosalie  4a. Facility Name (If not institution,	T.	Swar	111	4b. City.	Town, or	Location o	of Death	march_		nty of Death		U a.m.
	Examin	er							nardt			Q.	t. Ma:	t a	
	Funeral		St. Mary's I	6. Sex		yrs. last birthda		1 Year	If Under :	24 Hrs.	8. Date of Birt	h			ite or Foreign
	Director		214-66-4893	1 ☐ M 2 🗑 F		95 Yrs.	Months	Days	Hours	Min.	(Month, Da) June 2	9.1909		<i>intry)</i> rylan	
	<b>D</b>		Usual Residence of Decedent												
	anylar show	_	10a. State 10b. County		10	c. City, Town or	Location						}		e City Limits Yes 2 PNo
	8a-1 s	cto		narles		· · · · · · · · · · · · · · · · · · ·		nedi	ct						63 2 2 140
	vith th	Directo	10e. Street and Number				10f. Zip	Code				10g. Citizen o	if What Cou	untry?	
	s 23s	rai	19206 Zack 1			-:	IMA - Dana		612	-i-2 /C-	- Ves es Ne	United	d Stat		
	er de	Funerai	11. Marital Status	Armed	ecedent Eve Forces? s 2  No	rin U.S.	If Yes, spec	erit of His	n, Mexican	, Puerto	ecify Yes or No- Rican, etc.)	14. B	lack, White		1,
36	rs aft	by F	1 ☐ Never Married 2 ☐ Marrie 3   Widowed 4 ☐ Divorced	If Yes, (	Give		1 ☐ Yes 2	2₽ No	Specify:			Spec	cify: Wh	ite	
ခို	filed within 72 hours after deeth with the Maryland Hygiene. kther then "natural", or ttems 23a or 28a-1 show snt, the Medical Examiner coust be notified at	ed	15. Decedent	s Education			edent's Usua					16b. Kind of	Business/I	ndustry	
212	nin 72 un "nu	piet	(Specify only highest Elementary/Secondary (0-12)		ed) e (1-4or 5+)	(Gi	e kind of wor DO NOT us	rk done di se retired)	uring most	t of worki	ng				
2	d with giene er tha	Completed	12	Conoge			Но	mema	ker			Own	n Home	9	
힏	e filed at Hygie other vent, the	Bec	17. Father's Name (First, Middle, L	ast)					18. Mothe	r's Name	(First, Middle,	Maiden Sum	ame)		
Maryland 21215-0036	2 should be and Mental Is marked o	ToE	Uriah Lee Ma	aguire						Jer	nie Chi	lng			
a	2 sho and h Is ma		19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Ma	ling Address	(Street a	nd Numbe	er or Rura	d Route Numbe	r, City or Tow	m, State, Zi	ip Code)	
Σ	₽ <b>5 5</b> ₽		Juanita Connic	k / Dau					reder		Road, I				
altimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any njury or other once.		20a. Method of Disposition 1 ■ Burial 2 □ Cremation	3 □Bemoval fro		20b. Place of Dis cemetery, ci	position (Nan ematory or o	ne of ther place	)		Date	20c. Location	n - City or T	Town, State	•
Ĕ	Pages nent of I ant: If Its ury or o		`4 □ Donation 5 □ Other (Sp			ld Fiel					.4,2005				
<u>a</u>	permit. Departnimports any nju		21. Signature of uneral service L	sensee			22. Name an	d Address	s of Facilit	<sup>y</sup> Brin	sfield-	-Echols	Funl	L.Hme	., P.A
<u> </u>	20 E 20		Edward N. Brinst	ield, J							Rd.,Char		Hall,	MD 2	3622
			23a. Part1. Enter the disease, or of shock, or heart failure. List of	complications that	at caused the n each line	death. Do not e	nter the mod	e of dying	, such as	cardiac c	r respiratory ar	rest,			Between
	Physician	0 1	Immediate Cause (Final disease or condition		6	Espi	ralo	u t	-au	ler	20_	3			nd Death
	/Medical		resulting in death)	Due t	to (or as a c	is qui ce of):		1	0	all courses	trocks.			n (	7
п	Examiner		Sequentially list conditions,	b		ME	un	von	na					Ja	sul)
	sit ad	ine	Lary leading to immediate cause. Enter Underlying Cause (Disease or injury	Due t	to [or as a c	insequence of:									
	and -trans	Examiner	that initiated events resulting in death) Last	c	to (or as a co	onsequence of);									V
8760,	ate be executed thysician and the burial-transit	E			.0 (0. 00 0 0	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,									
	ate thy the	dicai		d			<del></del>								
9 ×	death certific e attending p ed for use as l	Physician/Me	IF FEMALE:	23c. If yes, o	outcome of p	regnancy						23d F	Date of deliv	/en/	
Box	atten for u	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live		Fetal death	☐ Ectopic pro						Month	Day	Year
o.	0 0	ysi	1 □ Yes 2 🗭 No 9 □ Unknown	lnU□e											
בֿ	requires that the de een signed by the a hould be detached f	V P	Part II. Other significant condition	s contributing to	death but no	ot resulting in the	underlying ca	ause give	n in Part I.		23e. Did to	bacco use co	ntribute to	the cause	of death?
g	uires sigr ld be	d by		<i>p</i>							1 🗆 Y	es 2 🐯 No	3 🗆 Pro	bably 4	□Unknown
Vital Records,	> 0 0	Completed	Den	monti's							24a. Was	an 24t	. Were aut	opsy findin	igs available
Ř	The law ate has b page 2 st	E D		100000							autop	sy med?	prior to co death?	ompletion	of cause of
g	ician: Th certificate rector, pag	e Cc	25. Was case referred to medical						oc Place	of Dooth	1 ☐ Yes	2 No	1 🗌 Yes	2 <b>12</b> No	
	Physician: r this certifica ral director, p	o Be	examiner?  1 \sum Yes 2 \lefta No	Hospital:	☐ Inpatient	2 ER/Outpati	ent 3⊡ DO	Other	_		ne 5 ☐ Resid		ther (Spec	ifu)	
Division of	Phy or this aral d	$\vdash$	27. Manner of Death		te of Injury onth, Day Ye		of 2	8c. Injury	at		28d. Describe h			1197	
O	ttsnding F death. tor: After the funera	tlor	1 ■Natural 5 ☐ Pending 2 ☐ Accident investig	I NY	onth, Day Ye	ear) Injury	М	WOLK.	? ′es 2. []1	No					
/IS	or Attsnding after death. Director: After In by the fune	ifica	3 ☐ Suicide 6 ☐ Could not determine		ce of Injury	At home, farm,	street, factory	, office			28f. Location (S		nber or Rui	al Route N	lumber,
á	al or Att	Certification:	4   Hottlicide	DUI	ilding, etc. (S	ьр <del>өс</del> іту)				- V	City or Tow	n, State)			
	To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by			Physician: To t											- (-)
	n 24 he Fu he Fu	Medical	one)	xaminer: On the	anner stated		investigation,	, in my opi	inion, deal	ur occurr	ed at the time, (	ale and place	), and due i	to the caus	e(s)
	To t To t	Σ	29b. Signature and title of certifier			11	A 29c	. License	number	///	(0)	29d. Date sigr	ned (Month,	, Day, Yea	7)
			bar	nart	pull	TE/V	1)	D	DE	o 41	7	3-	.14-	-05	
			30. Name and address of person v	no completed da	ase of death	(Item 23a) (Typ	e, Print)								
				boe, M.I		035 Thre			ad, I	Holl	ywood,	Maryla	nd 20	636	
	Sta		31. Date filed (Month, Day, Year)	32	. Projistrar's	Signature	Social	,							
	Registr	ar	MAR 1	2005	A CONTRACT	1 15 1	1000								

			1 - For State Registrar	State of Maryl		artment of I			ene 005	10128
	Physici /Medic		1. Decedent's Name (First, Middle, Las Joseph B. Si	mpson, Jr.				2. Date of Death March 1	7°, 2005	3. Time of Death 1:44 AM
	Examin		4a. Facility Name (If not institution, give 9650 Old Sycam				or Location of Death		4c. County of De	
	Funeral Director	4.1	213-44-4070	ex 7. Age (In g	vrs. last birthday 63 Yrs.	) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, ) Dec. 29		inthplace (State or Foreign Country) aryland
	nyland how		Usual Residence of Decedent  10a. State 10b. County		. City, Town or L					10d. Inside City Limits
	the Ma	ecto	MD Charl  10e. Street and Number	es	Charl	otte Ha	11	100	g. Citizen of What (	1 Yes 2 No
	23s or	al Dir	9650 Old Sycam	ore Rd.			622	100	U S A	Southly :
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event. Its Madical Eventil art and be neithed at once.	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Amed Forces? 1 ∑Yes 2 ☐ No If Yes, Give Year or Dates:	n U.S. 13.	Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☑ No	Hispanic Origin? (Spi an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wh Specify:	nerican Indian, nite, etc. White
21215-0036	in 72 ho	Be Completed	15. Decedent's Ed (Specify only highest gra	de completed)	16a. Dece (Give life.	edent's Usual Occup e kind of work done DO NOT use retire	oation during most of work id)	ing 16	Sb. Kind of Busines	ss/Industry
212	ed with ygiene. ner thar	Com	Elementary/Secondary (0-12)	College (1-4or 5+)		uce Manag	er		Grocery	Store
and	id be fill ental H ked oth ic even	To Be	17. Father's Name (First, Middle, Last)  Joseph B. Simpso				18. Mother's Name Sarah D	e (First, Middle, Ma avis	aiden Sumame)	
, Maryland	ind 2 shou alth and M 127 Is mar or treumat	-	19a. Informant's Name/Relationship (7 Irma Simpson/wife	Type, Print)			and Number or Rura			
Baltimore,	Pages 1 ament of He ant; If item ury or othe		20a. Method of Disposition  1   ↑ Burial 2 □ Cremation 3 □  ↑ 4 □ Donation 5 □ Other (Specify	Removal from State	cemetery, cre t. Mary	osition (Name of ematory or other pla	emetery 3/	21/05 No	ewport, M	laryland
Balt	permit. Depart Import any inj		21. Signature of Funeral Service Licen	\$ 5th	P	2. Name and Address. A., 3019	ess of Facility Bri 5 Three N	nsfield-lotch Rd.	chols Fu , Charlot	neral Home, te Hall MD
68760,	hysician and water transit street be executed by Medical Examiner street	al Examiner	23a. Part1. Enter the disease, or company shock, or heart failure. List only disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a con Due to (or a con Due to (or a con Due to (or a con Due to (or a con Due to (or a con Due to (or a con Due to (or a con Due to (or a con Due to (or a con Due to (or a con Due to (or a con Due to (or a con Due to (or a con Due to (or a con Due to (or a con Due to (or a con Due to (or a con Due to (or a c	sequence of):	ster the mode of dyi	ng, such as cardiac d	Course Course	it,	Approximate Interval Between Ogset and Death
P.O. Box 687	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1 Live birth 2 1 4 Pregnant at time 9 Unknown	etal death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of d Month	elivery Day Year
	w requires that i been signed by should be deta	by	Part II, Other significant conditions of	ontributing to death but not	resulting in the I	underlying cause gr	ven in Part I.			to the cause of death?  Probably 4X Unknown
Division of Vital Records,	The law requate has been page 2 should	Completed						24a. Was an autopsy performe	prior to death?	autopsy findings available completion of cause of es 2 X No
Vita	sician: certific irector,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2X No	Hospital: 1 ☐ Inpatient	2	nt 3□ DOA Oth		(Check only one)		
n of	ng Phy Iter this	-	27. Manner of Death 1 X Natural 5 □ Pending	28a. Date of Injury (Month, Day Yea	28b. Time o	EIL SEIDON	ry at	28d. Describe how	ce 6 Other (Sp	өсту)
Divisio	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	ertification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined				Yes 2 No	28f. Location (Stre City or Town,		Rural Route Number,
J	To the Hospital or A within 24 hours after To the Funeral Direc completely filled in by	edical Ce	29a. Certifier Check only one)	ysician: To the best of my niner: On the basis of exan	knowledge, dea nination and/or in	th occurred at the tinvestigation, in my	me, date and place, opinion, death occurr	and due to the cau	se(s) and manner are and place, and di	as stated. ue to the cause(s)
)	To the within ? To the comple	Mec	29b. Signature and title of certifier	and manner stated.	Du	29c. Licens	oz 875	290	d. Date signed (Mod	
11	5		30. Name and address of person who anniel Howell,	completed cause of death M.D., 605 Ch	Item 23a)(Type arles S	Print) treet, La	Plata, M	D 20646		
	Sta Registr	4,6	31. Date filed (Month, Day, Year)  MAR 1 8 20	32 Registrar's S	ignature	and .				

			1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	ertificate of		nd Mental Hy	/giené	005	10129		
	<b>D</b>		1. Decedent's Name (First, Middle,	Last)				2. Date of D	eath		3. Time of Death		
	Physici /Medio		TH	ELMA WAT	rs SMIT	H		MARO	CH 6,	2005	8:40 PM		
	Examir	er	4a. Facility Name (If not institution, s			4b. City, Town, of Gaithe				ounty of Death	MERY		
	Funeral Director		5. Social Security Number 579-24-1285		e (In yrs. last birthda) 93 Yrs.	) If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of Bi Min. (Month, D Mar. 2	av. Year)	9. Birthp	place (State or Foreign htty) aryland		
	and		Usual Residence of Decedent  10a, State 10b, County		10c. City, Town or I	ocation				1	0d. Inside City Limits		
	Maryli f sho	Į.		gomery		Gaithers	sbura			'	1 ☐ Yes 2√E No		
	r 28a	irec	10e. Street and Number			10f. Zip Code			10g. Citizer	n of What Cour			
	238 o	ai D	18519 Straw	berry Kno	ll Rd.	2	20879		1	U.S.A.	-		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show minportant: If item 27 is marked other than "helical Evarting minal be notified and once.	by Funerai Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒️Widowed 4 □ Divorced	12. Was Decedent Armed Forces?  1  Yes 2  If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Originan, Mexican,  Specify:	n? (Specify Yes or No Puerto Rican, etc.)		Race - Americ Black, White, pecify:			
21215-0036	2 hou	ted	15. Decedent's	Education	16a. Dec	edent's Usual Occup	ation		16b. Kind	of Business/Inc	dustry		
215	hin 7.	pie	(Specify only highest Elementary/Secondary (0-12)	grade completed)  College (1-4or 5	lite	b kind of work done  DO NOT use retired	during most of	of working			ed Army		
2	ygien ygien rer th	Completed		2 yrs		Nurse			Med:	ical C	enter		
Maryland	12 should be filed within "h and Mental Hygiene." 7 is marked other than "Iraumatic event, the Med	Be	17. Father's Name (First, Middle, La				18. Mother's	s Name (First, Middle	, Maiden Su	mame)			
Ž	hould id Mer mark matic	٦	Unkno 19a. Informant's Name/Relationship		10h Mai	ing Address (Street	and Numbor	Unknown	or City or To	Otata Tia	Code) 20879		
Z S	nd 2 s lith an 27 is.		Fred Scott (		195	19 Straw	berry	Knoll E	Rd., (	Gaithe	ersburg,MI		
J.	of Heal		20a. Method of Disposition		20b. Place of Disp			Date		ion - City or To			
<u>ii</u>	Page		1 🔀 Burial 2 □ Cremation 3  `4 □ Donation 5 □ Other (Spe		Gate o	f Heaver	Cem	3/12/05			ring,MD		
Baltimore,	permit. Departr Importa any inj		21. Signature of Funeral Service Lic	9169							ome, P.A.		
	© ∪ E @ 0	11 1	Leoige	1 sus				gton St.		ckvill	e, MD		
	III seletes		23a. Part1. Enter the disease or co shock, or heart failure. List or	inplications that ceused ity one cause on each lin	the death. To not en	ter the mode of dyin	g, such as ca	irdiac or respiratory a	rrest,		interval between		
	Priysician /Medical		disease or condition resulting in death)	onset and Death Conset									
	Examiner				a consequence of):	2277							
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to ( as a	ertensio a consequence of):	n							
	cuted nd transit	Examiner	Cause (Disease or injury that initiated events	с									
90,	oe exe cian a vurial-i	EX	resulting in death) Last	Due to (or as	a consequence of):								
8760,	icate be executed physician and s the burial-transit	dical		d									
	The law requires that the death certific. Its has been signed by the attending p. page 2 should be detached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth	2 Fetal death 3	Ectopic pregnancy			23d.	Date of delive	ry Day Year		
P.O.	at the de by the a tached f	ysic	1 Yes 2 No	4□ Pregnant at 9□ Unknown	time of death 5	Other (specify)				World	Day Teal		
ري. ص	res that igned b be deta	by Pt	Part II. Other significant conditions	s contributing to death bu	ut not resulting in the	inderlying cause give	en in Part I.	23e. Did t	obacco use o	contribute to th	e cause of death?		
ord	w require been sig should b							11	Yes 🏖 N	o 3 🗆 Proba	ably 4 Unknown		
Records,	law ri las be	Completed						24a. Was		4b. Were autop	osy findings available		
<u> </u>	cate has	Co						perfo	rmed?	death? 1 ☐ Yes			
<u> </u>	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		at 3 Dog Othe		Death Check onl			7.		
Division of Vital	Phys or this oral di	:. To	1 Yes 2 No 27. Manner of Death	28a. Date of Injur	y 28b. Time o	II 3 DOX	4 🗀 140151	ng Home 5 E Resident					
lo	ath. r: Afte e fune	ation	1 Natural 5 ☐ Pending 2 ☐ Accident Investigat	(Month, Day	Year) Injury	f 28c. Injury Work M 1 []	k? Yes 2∐No		,,	11011	C		
N N	r Atte er de recto	Certification:	3 Suicide 6 Could not	28e. Place of Inju-	ury - At home, farm, st c. (Specify)	reet, factory, office		28f. Location (: City or Tox	Street and Nu	umber or Rural	Route Number,		
	ital o urs aft rel Di												
	To the Hospital or Attending Physician: within 24 hours stater death. To the Funeral Director: After this certifical completely filled in by the funeral director;	edicai	29a. Certifier (Check only one) Certifying 2 Medical Ex	Physician: To the best of aminer: On the basis of and manner sta	examination and/or in	h occurred at the tim vestigation, in my or	ne, date and pointion, death	place, and due to the occurred at the time,	cause(s) and date and plac	I manner as sta ce, and due to	ited. the cause(s)		
	Veith Com	Σ	29b. Signature and title of confifier	~ M	10	29c. License	number		29d. Date sig	gned (Month, D			
}	6		, , ,	/ // /	V-		4216		Mar				
			30. Name and address of person who Brigette Abr		eath (Item 23a) (Type,	Print) 04-E Da	rnest	own Rd.,	Gait	hersbu	arg, MD		
	Sta	е	31. Date filed (Month, Day, Year)		r's Signature								
	Registra		MAR 102	005 Bosen	r's Signature	ule)							

		1 - For State Registrar	State of Maryl	and / D	epartment of F	lealth and M	lental Hygie	•	10130			
		1. Decedent's Name (First, Middle, La	st)		-	· ·	2. Date of Death		3. Time of Death			
Physici /Medio		BOYD C.	SMITH				Month MARCH	Day Year 8 2005	17:50 M			
Examir		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, o	r Location of Death		4c. County of Death				
		13805 Clarksvill	e Pike, Rout	e 108	High	land		Howar	đ			
Funeral		Social Security Number     6. S		rs. last birti	hday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min,	8. Date of Birth (Month, Day, Y	9. Birth	nplace (State or Foreign untry)			
Director		238-24-3650	<b>⊠</b> M 2□F 82		rs. World's Days	Hours Will.	March 5	1923   Nor	th Carolina			
D		Usual Residence of Decedent  10a, State 10b, County	1100	Ch. T.	or Location							
anyla shov	-	Md. Howard		* '	hland				10d. Inside City Limits			
Ba-f	cto			nig.	IIIaiiu	***************************************			1 ☐ Yes 2 📆 No			
ith th	Funeral Director	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Co	•			
ath v 23a	a	13805 Clarksvill	· · · · · · · · · · · · · · · · · · ·			20777		United St	ates			
tams	une	11. Marital Status	12. Was Decedent Ever in Armed Forces?	n U.S.	13. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White				
orl	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 □ No If Yes, Give	WWII	1 ☐ Yes 2 🛣 No	Specify:		Specify: W	hite			
hour tural	D D		Year or Dates:	150	Danadania Harri Oarra		1.0					
"na"	Completed	15. Decedent's Ed (Specify only highest gra	ide completed)		Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	during most of worki	ing 16	b. Kind of Business/I	ndustry			
withi ene. than	mg	Elementary/Secondary (0-12)	College (1-4 <i>o</i> r 5+)	m	raffic Engi	,		Telephone	Company			
filled Hygi thar int,	Ö	17. Father's Name (First, Middle, Last,		1	ratife Engi		(First, Middle, Ma		Company			
d be antal	o Be	Clarence L.	Smith			Nannie	Moore	,				
mark matt	2	19a. Informant's Name/Relationship (		19b.	Mailing Address (Street			ity or Town State 7	in Code)			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural", or Itams 23a or 28a-f show appropriant: If Item 27 Is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic evant, the Medical Exam har must be notified at another.		Edna S. Smith /							d, Md. 20777			
1 ar Hea tem 3		20a. Method of Disposition		b. Place of	Disposition (Name of	! C	-	c. Location - City or 1				
O S E o O		1 Burial 2 Cremation 3			, crematory or other place							
artme ortani njury		<ul> <li>4 □ Donation 5 □ Other (Specifical Service Liceration)</li> <li>21. Signature of Funeral Service Liceration</li> </ul>		etrop	olitan Crem 22. Name and Addre		9/05 A	lexandria	, va.			
Depare Impo		21. Signatura di Francia Servica Elcar	Balan		Muriel H	. Barber						
		23a Part Enter the Issasse or com	nlications that caused the d	eath Don	P. O. B	$0x_5038$	Laytonsvi	lle, Md.	20882 Approximate			
		23a. Part1. Enter the insease, or com shock, or head in ure. List only Immediate Cause (Final	one cause on each line.	Out	or drives the mode of dyn	ig, sport as cardiac c	respiratory arrest		Interval Between Onset and Death			
Physician /Medical		disease or condition resulting in death)	a MYOCARDIA						Minutes			
Examiner			Due to (or as a cons		n:							
	<u> </u>	Sequentially list conditions, if any, leading to immediate	b. HYPERTENS		<b>∂</b> ·				-			
ted nsit	n lu	cause. Enter Underlying Cause (Disease or injury										
xecu and al-tra	хаг	resulting in death) Last  Due to (or as a consequence of):										
be executed sician and burial-transit	icai E											
physicate t			. d									
eath certific attending p	/We	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre	gnancy				23d. Date of deliv	1001			
atter I for u	ciar	in the past 12 months?	1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of		3 □Ectopic pregnancy 5 □ Other (specify)	,		Month	Day Year			
at the de by the tached	Physician/Med	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown	1112								
The law requires that the death certificate be executed tite has been signed by the attending physician and bage 2 should be detached for use as the burial-transit		Part II. Other significant conditions of	ontributing to death but not	resulting in	the underlying cause giv	en in Part I.	23e. Did tobac	co use contribute to	the cause of death?			
uires 1 sign 1d be	d by				4		1 ☐ Yes	2 □ No 3 🗗 Pro	bably 4 Unknown			
w require been si should t	Completed					-	24a. Was an	24h Woro aut	ppsy findings available			
The lav	d L						autopsy	prior to co	ompletion of cause of			
		05 14/					1 Yes 2	No 1 □ Yes	2 No			
Physician: r this certific ral director,	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	Перио .	Oth	er:			NO			
Phys rthis ral di	H	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	ER/Out			ne 5 A Residenc 28d. Describe how	e 6 Other (Speci	fy)			
ding th. After funer	tior	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year		jury Wor	k? Yes 2 □ No		,,				
Attan deal ctor y the	fica	3 Suicide 6 Could not b		t home, fan		_	28f. Location (Stree	t and Number or Rui	al Route Number.			
al or Attanding f s after death. I Director; After d in by the funer	Certification	4 Homicide	building, etc. (Spe	ecify)	, , , , , , , , , , , , , , , , , , , ,	1	City or Town, S					
spita lours naral fille		29a. Certifier 1 Certifying Ph	ysicien: To the best of my	knowledge,	death occurred at the tin	ne, date and place, a	and due to the caus	e(s) and manner as	stated.			
To the Hospital of within 24 hours af To the Funeral D completely filled in	Medical	(Check only 2 Medicel Exam	niner: On the basis of exam and manner stated.	ination and	for investigation, in my o	pinion, death occurre	ed at the time, date	and place, and due t	to the cause(s)			
To th withir To th	Me	29b. Signature and title of certifier	7 /		29c. Licens	e number	29d.	Date signed (Month,	Day, Year)			
	,	> End//	Mho		725	947	ma	Ren 8,2	005			
70+		30. Name and address of person who	completed cause of death (I	tem 23a) (1		, , ,		, ^	0			
~ '		EVELYN JACKSON,	M.D. 5540	TEN O	AKS ROAD, C	LARKSVILL	E, MD.	21029				
Sta		31. Date filed (Month, Day, Year)	32. Rigistrar's Si	gnature	Snarke							

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

			1 - For State Registrar		Maryland / Dep <i>Ce</i>	artment of F		nd Mental Hy	giene 05	10131						
	Physici	an	Decedent's Name (First, Middle	•				2. Date of De Month	eath Day Yea	3. Time of Death						
	/Media	cal		tengler		T		March	11, 200	7:30 PM						
	Examir	ner	4a. Facility Name (If not institution	-		4b. City, Town, o		Death	4c. County of D							
	Euroval		St. Mary's Nur  5. Social Security Number	6. Sex 7.	C Age (In yrs. last birthday)	Leonard If Under 1 Year	Itown,	4 Hrs. 8. Date of Bi	St. Ma							
	Funeral Director		401-18-0693	1□M 2★F	85 Yrs.	Months Days	Hours	Min. (Month, D. Nov. 2	ay, Year) 27, 1919 K	Birthplace (State or Foreign Country) entucky						
	pc ,		Usual Residence of Decedent						.,	entucky						
	show	-	10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits						
	Me M	Funeral Director	Kentucky Jeff	erson	Louisvi					1XXYes 2 □ No						
	a or	급				10f. Zip Code			10g. Citizen of What	Country?						
	leath	eral	2211 Tyler Lar	12. Was Decede	nt Ever in U.S. 13	40205		in? (Specify Ves or N	U.S.A.	merican Indian,						
(O	r iter	필	1 Never Married 2 Marri	Armed Force ed 1 ☐ Yes 2  X	s?			in? (Specify Yes or No Puerto Rican, etc.)	Black, W							
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23s or 28s-f show he Madical Examinar must be myllhed at	þ	₩Widowed 4 Divorced	If Yes, Give Year or Date		1 ☐ Yes <b>XX</b> No	Specify:		Specify:	White						
5-0	72 h natu	Completed	15. Decedent (Specify only highes	s Education t grade completed)	(Give	dent's Usual Occup	durina most a	of working	16b. Kind of Busine							
121	Mithin ne.	Id III	Elementary/Secondary (0-12)	College (1-4d	or 5+)	DO NOT use retired	1)	g								
2	filed v Hygie other t		12 17. Father's Name (First, Middle, I	ast)	Ho	ne Maker	19 Mothor	s Name (First, Middle	Own Hom	e						
Maryland	s 1 and 2 should be filed within 72 hours after death with the Manylan if Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examinar must be instilled at	o Be	Joseph Beatty			i i										
Z	shout nd Me mark marti	ြ	19a. Informant's Name/Relationsh	ip (Type, Print)	19b. Mailii	ng Address (Street a		phine Pyle	er, City or Town, State	Zin Code)						
	and 2 ealth a n 27 is		Joseph O. Knoe	efel / Son						ryland 20619						
Baltimore,	permit. Pages 1 and 2 Department of Health Important: If item 27 any injury or other tra once.		20a. Method of Disposition		20b. Place of Dispo	sition (Name of matory or other place		Date	20c. Location - City							
Ē	Pages nent of h int: If its		1 X Burial 2 ☐ Cremation  1 4 ☐ Donation 5 ☐ Other (Sp		Resthave	,		8-18-05	Louisvill	e, Kentucky						
alti	permit. I Departm Importal any inju		21. Signature of Funeral Service	Signature of Funeral Service Cee ee 22. Name and Address of Facility Brinsfield Funeral Home, P.A. P.O. Box 279 Leonardtown, Maryland 20650-0279												
<u> </u>	89789		EdealAS	m/	P.	.O. Box 2	79 Leo	nardtown,	Maryland 2	20650-0279						
Н			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
	Physician	î î	Immediate Cause (Final disease or condition	ATHO	ROSCLEROTI	C CARIS	10 VASC	DEAR IST	with.	Onset and Death						
	/Medical Examiner		resulting in death)		as a consequence of):					YEAR						
		<u></u>	Sequentially list conditions,	D	WeWAY TIS	risis				(-").5						
	ted nsit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (d) a	as a consequence on.											
	axecu n and al-tra	xar	that initiated events resulting in death) Last	c Due to (or a	as a consequence of):											
8760,	cate be executed physician and the burial-transit	dical														
9	ifficat g phy as the	edic		J												
Вох	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom		Ectopic pregnancy			23d. Date of d	elivery						
	deat	sicie	in the past 12 months? 1 ☐ Yes 2 ☐ No		at time of death 5 [	Other (specify)			Month	Day Year						
P.0	that the de ed by the detached	Phy	9 Unknown													
Ś	ires tha signed 1 be de	by	Part II. Other significant condition	is contributing to death	but not resulting in the u	nderlying cause give	en in Part I.		obacco use contribute							
O.C	w requir	eted						_ '''	Yes 2 No 3 1	Probably 4 Honknown						
ec	m _ c o	ompleted						24a. Was autor	osv prior to	autopsy findings available completion of cause of						
al F	ian: The I rtificate ha rtor, page	0						1 Yes	rmed? death?	es 2.12 No						
Vital Record	5 8 9 E	o Be	25. Was case referred to medical examiner?	Hospital:		Othe		f Death (Check only o								
of	Phys	$\vdash$	1 ☐ Yes 2 ☑ No  27. Manner of Death	1 ∐ Inpa 28a. Date of In	jury 28b. Time of	t 3 DOA 28c. Injury	at Nursi		dence 6 Other (Sp	ecify)						
O	Attending Ph r death. sctor: After th by the funeral	tion	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investiga	(Month, E	Day Year) Injury	Work	ເ?ົ ∕es 2.∐No		iow injury occurred							
Division	N or Attendi after death. I Director: A d in by the fu	Certification:	3 Suicide 6 Could not determine	and 286. Place of I	njury - At home, farm, stre	eet, factory, office		28f. Location (5	Street and Number or I	Rural Route Number,						
Ō	s afte	Sert	4 - Hothicide	building,	etc. (Specify)			City or Tov	vn, State)							
	Hospital		29a. Certifier 1 Certifying	Physician: To the bes	of examination and/or inv	occurred at the tim	e, date and p	place, and due to the	cause(s) and manner	as stated.						
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Medical	5.10	and manner	stated.											
	To To Con	Σ	29b. Signature and little of certifier		4.1	29c. License	number		29d. Date signed (Moi	nth, Day, Year)						
,			Lille		MD	1 1000	16		3.14.05							
			30. Name and a ss of person w	no completed cause of	death (Item 23a) (Type, I	Print)	=K /	harry da	AAI	2082						
	Sta	to	31. Date filed (Month, Day, Year)	32. Reg	rar's Signature	100(M/E	()) '	requer	) ////	7 5 5 5 6						
	Registr			7 2005	death (Item 23a) (Type, SYAH AS	goest.										

			For State Registrar	State of Ma		d / Depa		t of H	ealth and			<b>e</b> 005	013	32
			Decedent's Name (First, Middle, Las	it)						2. Date of I		ay Year	3. Time of	Death
	Physicia		Charlotte Trice S	mith						March		2005	9:38	РМ
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)			4b. City,	Town, or	Location of De	ath	4	c. County of Deat	h	
			William Hill Man				East					Talbot		
	Funeral		5. Social Security Number 6. S	ex 7. Age		last birthday)	If Under Months	1 Year Days	If Under 24 H Hours Mi		Birth Da <i>y, Yea</i>	9. Birt	nplace (State o untry) y Land	r Foreign
1	Director		218-20-8148		7	8 Yrs.				May 1	0,19	Zo Mai	yrand	
6	and w		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside Ci	ity Limits
7	daryl f sho	ō	Maryland Dorchest	or	Fa	st New	Mark	et					1 ☐ Yes	2 📉 No
H	with the Maryland to or 28e-1 show	rec	10e. Street and Number		- Lju	DC NOW	10f. Zip	_			10g. C	itizen of What Co	untry?	
ENE	3a ol	Funeral Directo	5834 Thompsontown	Road				2163	1			USA		
0	death	ner	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U	.S. 13. V	Vas Deced	lent of Hi	spanic Origin?	(Specify Yes or lerto Rican, etc.)	No-	14. Race - Ame Black, Whit		
ထ္	or Ite	F	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 ☑N If Yes, Give Year or Dates:	ło		Yes :		Specify:			C	nite	
93	ural',	d by	3 XWidowed 4 □ Divorced								4.05	***		
5	72 h "natu	Completed	15. Decedent's Ec (Specify only highest gra	ducation ade completed)		16a. Deced	ient's Usua kind of wor DO NOT us	il Occupa rk done d	ation Juring most of v )	vorking	160.	Kind of Business/	industry	
12	within nne. than	m du	Elementary/Secondary (0-12)	College (1-4or 5	+)	Posta			,		US	Posta1	Service	<u> </u>
7	iled v Hygle ther i	ပိ	17. Father's Name (First, Middle, Last)	)			-		18. Mother's N	lame (First, Midd	ile, Maide	an Sumame)		
anc	nntal I	Be C	Lloyd Nichols Tri						Beulah	Bradley				
2	shoute nd Me mark matik	2	19a. Informant's Name/Relationship (			19b. Mailin	ng Address				ber, City	or Town, State, 2	Zip Code)	
N S	ad 2 s Ith ar 27 is r treu		James B. Nichols/	Nephew		5953	Green	Poi	nt Road	l, East	New 1	Market,M	D 21631	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other treumatic svent, the Medical Examinat must be multified at once.		20a. Method of Disposition		20b. F	Place of Dispo	sition (Nar	ne of ther plac	θ)	Date	20c.	Location - City or	Town, State	
ê	Page ento nt: If ry or		1 Burial 2 □ Cremation 3 □ 1 Donation 5 □ Other (Specif		- 1				ı	12/2005	Hur	lock, Ma	ryland	
a E	mit. Joachm Sorta Vinju		21. Signat re of Fune ral Service Lice	nser	11	22	e Name an	d Addres	eraility	ome, P.	0. B	ox 207 rket, MD		
ä	e d E s d		recover	N	Le le							rket, MD		
•	Physician /Medical Examiner	-	293. Part 1 Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.	a.  Due to (or as	a consec	quence of):	er the mod	e of dyin	g, such as card	liac or respiratory	arrest,		Approximat Interval Bet Onset and	ween Death
,160,	ite be executed ysician and ne burial-transit	Icai Examiner	Sequentially list conditions, if any, leading to him ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consec	quence of):								
P.O. Box 687	Attending Physician: The law requires that the death certificate r death. r death. ector: After this certificate has been signed by the attending phys by the funeral director, page 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Feta	aldeath 3	Ectopic p				-	23d. Date of de Month	-	Year
	uires that signed b	þ	Part II. Other significent conditions	contributing to death b	out not res	sulting in the u	nderlying o	cauşe giv	en in Part I.		d tobacc □Yes	o use contribute to	o the cause of cobably 4 🖃	The same of the sa
00	w require been signal	ompleted	Hyperkensier	)		_ /				24a. W	as an	24b. Were a	topsy findings	available
Re	The lav	III.	1	Jako. As	12	no. 1	)			pe	itopsy orformed? s 2 ☑ I	death?	2 □ No	2030 01
<u>a</u>	ician: Th certificate rector, pag	Ö	25. Was case referred to me	Cuece!	170	nex			26. Place of	ath Check on				
Š	ystcian: is certific director,	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	ent 2	ER/Outpatier	nt 3 🗆 D0	Oth Oth	er: 4 Z Nursin	g Home 5□R	esidence	6 ☐Other (Spe	cify)	
Division of Vital Records,	nding Phys th. :: Atter this e funeral di		27. Mann of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	iry <i>y Year)</i>	28b. Time o Injury	f M	28c. Injur Wor 1 🗀	yat k? Yes 2 □ No	28d. Descri	e how in	jury occurred		
Divis	al or Attendii s after death. it Director: A	Certification:	3 Suicide 6 Could not l	28e. Place of Inj building, et	ury - At h lc. <i>(Speci</i>	nome, farm, st	reet, factor	y, office			n (Street Town, St	and Number or R ate)	ural Route Nun	nber,
	To the Hospital or Attand within 24 hours after death To the Funeral Director: completely filled in by the	edical	29a. Certifier 1 Certifying P (Check only one) 2 Medicei Exe	hysician: To the best miner: On the basis o and manner st	f examin	owledge, deat ation and/or in	vestigation	n, in my o	pinion, death o	ace, and due to to courred at the tin	ie, date a	and place, and du	to the cause(s	s)
	To the To the Comp	Σ	29b. Signature and title of certifier	11 /	9		29	/	e number			Date signed (Mon		
			N m/	Macy	V	91)		De	8871	7	Ma	rch 9, 2	005	
			30. Name and address of person who					_						
_			William H. Wood,				Lane	, Ea	ston, N	1D 21601				
	St Regist	ate	31. Date filed (Month, Day, Year)  MAR 1	1 2005 Regis	ars sign	nature /	dos	ek.						

			1 - For State of Maryland / Department of Health and N Registrar Certificate of Death	lental Hygi	3	10133
			1. Decedent's Name (First, Middle, Last)	2. Date of Death		3. Time of Death
	Physici /Medio		Esther P. Stanley	March 8	, <sup>Day</sup> 2005 Year	0028 м
)	Examir		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death		4c. County of Death	
			Dorchester General Hospital Cambridge		Dorche	
	Funeral Director		5. Social Security Number 217-30-8248  Consider Security Number 6. Sex 1	8. Date of Birth (Month, Day, 1) May 15,		place (State or Foreign ntry) cyland
	<b>6 W</b>		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
S	nous arer beam win me maryland turel', or Items 23a or 28e-f show al Examiner must be notified at	ţō	Maryland Dorchester Fishing Creek			1 ☐ Yes 2 ☐ No
7	or 28e	Funeral Director	10e. Street and Number 10f. Zip Code	10	g. Citizen of What Cou	ntry?
3	23a (	al	1218 Lodge Hall Road 21634		USA	
8	r dems	nei	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
36	or II	by Fu	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes 2 No Specify:		Specify:	
8	ture	ed b	Wildowed 4 Divorced Year or Dates:  15. Decedent's Education 16a. Decedent's Usual Occupation	14	What is the second seco	nite
21215-0036	n "n8	Completed	(Specify only highest grade completed) (Give kind of work done during most of work life. DO NOT use retired)	ing	bb. Killd Of Businessyin	austry
212	jene.	mo	Selementary/Secondary (0-12) College (1-4or 5+)  9  Crab Picker		Shellfis	sh
פ	be High winn 72 mouts after beam with the marylar that Highene and other then "neturel", or flems 23a or 28e-f show event, the Medical Examiner must be notified at	ВеС		e (First, Middle, Ma		
Val	nd Menta marked imetice	ဥ	Ulman Lankford Lewis Novella	Hattie I	Lewis	
Maryland	s I and 2 should f Health and Mer item 27 Is marke other treumetic		19a. Informant's Name/Relationship ( <i>Type, Print</i> )  19b. Mailing Address ( <i>Street and Number or Run</i>			
	Health Health Iem 27		Marvin O'Neill Stanley, Sr./Spouse 1218 Lodge Hall R			
0	or othe		1 Buriai 2 ☐ Cremation 3 ☐ Removal from State   cemetery, crematory or other place)		c. Location - City or To	
Baltimore,	rtmer rtant njury		'4 □Donation 5 □Other (Specify) DorchesterMemorialPark 3/1  21. Strature of Funeral Service Licensee 22. Name and Address of Facility			Maryland
Ва	permit. Prages Department of It Important: If ite eny injury or of		21. Scholler of Funeral Servic Licensee  22. Name and Address of Facility Curran—Bromwell F 308 High St., Cam	uneral Ho	me 21 P14.	
			23a Part I Enter the disease or complications the caused the death. Do not enter the mode of duing such as conding			Approximate
P	hysician		shock, or heart failure, list only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate  Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):		Interval Between Onset and Death	
	/Medical		resulting in death)  Due to (or as a consequence of):			
	xaminer		Sequentially list conditions, b. Multisystem Organ Fallers			
7	sit an	lne	cause. Enter Underlying			
- 200	and I-tran	Examiner	Cause (Disease or infury that initiated events c. resulting in death) Last Due to (or as a consequence of):			
8760,	hysician and the burial-transit	cal E				
687	physicate is the	8	d.			
Box 68	attending ph	N/	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of delive	эгу
<b>m</b>	ueall e atte	lcla	in the past 12 months?  1		Month	Day Year
P.O.	by th	Physician/M	9 Unknown 9L Unknown			
Records, P.O	wisquiles that the death been signed by the atter should be detached for	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Dissimilarities Introduciscular Conjugation	23e. Did toba	cco use contribute to the	ne cause of death? ably 4 □Unknown
000	as bee	Completed	Anoxic Brain Injury	24a. Was an		psy findings available
Ä Ä	ate has	mo	J	autopsy performa	d? death? Mo 1 ☐ Yes	mpletion of cause of
Vital	certificate rector, pag	Be C	25. Was case referred to medical 26. Place of Death	(Check only one)	72.00	
of Vita	his ce	2	examiner?  1 Yes 2 No	me 5 Residenc	ce 6 Other (Specifi	1)
0 0	ofter ti		27. Manner of De th  1 Natural 5 Pending  28a. Inte of Injury (Month, Day Year)  28b. Time of 28c. Injury at Injury Work?	28d. Describe how	injury occurred	
Sio	death.	cati	2 Accident investigation 3 Suicide 6 Could not be			
Division	Direct of Direct of In Dy	Certification;	4 Homicide  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Town,	et and Number or Rura State)	I Route Number,
Division	within 24 hours after death.  To the Funerel Director: After this certific completely filled in by the funeral director,	Medical C	29a. Certifier (Check only one)  Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner stated.	and due to the caused at the time, date	se(s) and manner as st and place, and due to	ated. the cause(s)
of c	vithin Fo the	Me	29b. Signature and title of certifier 29c. License number	29d	. Date signed (Month,	Day, Year)
) [	, r- 0		V0061877	M	arch 8, 200	05
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			
			Eric Joseph Widmaier, MD 503 Byrn St., Cambridge, M	D 21613		
	Sta Registr		31. Date filed (Month, Day, Year)  MAR 1 0 20 05   32. Register's Signature			

OFIGINAL

DHMH 17 Rev 1/2001

Registrar

Shyder, Jacque // NE

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death Department of Health and Mental Hygiene.

0)		For	State of Maryla	and / Dep	artment of Healti	n and Mental Hy	/giene		
· /	1	Stata Registrar		Ce	rtificate of Dear	th 2. Date of D	Reg. No.	005	10135
ysician Jedical aminer		Dacquelin  Jacquelin  a. Facility Name (If not institution, give	e A. S	Nyde	4b. City, Town, or Location	MARCH	Pay	2005 unty of Death	3. Time of Death 2158 M
aminer		THE MEMORIA		46	EASTON	/		LBOT	
eral ctor	- 1	. Social Security Number 6. S 213-24-1533	Sex 7. Age (In ye	rs. last birthday) Yrs.	Months Days House	der 24 Hrs. 8. Date of B Min. May 26	rth ay, 1927		ACE (State or Foreign YGTON, DC
	_	Usual Residence of Decedent  Oa. State  10b. County	10c.	City, Town or Lo	ocation			10	d. Inside City Limits
tor.		MD TALBOT		WITTMAN					XXYes 2 □ No
other traumatic event, the Medical Enaminer must be recitized at  To Be Completed by Funeral Director	1	0e. Street and Number	OAD		10f. Zip Code <b>21676</b>		-	of What Count	ry?
nera	1	22580 POT PIE R	12. Was Decedent Ever in Armed Forces?  1 Yes 2 No	U.S. 13.	Was Decedent of Hispanic If Yes, specify Cuban, Mexi	Origin? (Specify Yes or N	0- 14.	Race - America	
d by Fu	5	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2X No Spec	rify:		Black, White, e	ic. L <b>TE</b>
Completed		15. Decedent's E (Specify only highest gr	ade completed)	16a. Dece (Give	dent's Usual Occupation kind of work done during n DO NOT use retired)	nost of working		BERS AN	*
omo		Elementary/Secondary (0-12)	College (1-4or 5+) -0-		SECRETARY			FITTER:	
Be	1	7. Father's Name (First, Middle, Last				other's Name (First, Middle		name)	
To		FERDINAND B. HA		19b. Maili	ng Address (Street and Nu	MANNA BEREZOS		wn. State. Zip	Code)
97 1182	1	WILLIAM W. SINCLA	IR/ SON		EAST PINE DR			20737	
Once.	2	0a. Method of Disposition  1 ■ Burial 2 □ Cremation 3 □	Removal from State	cemetery, cre	osition (Name of matory or other place) LL CEMETERY	Date 3-17-2005	20c. Locati	on - City <i>o</i> r Tov	vn, State
ej .	2	<ul> <li>4 □ Donation 5 □ Other (Special</li> <li>21. Signature of Funeral Service Lice</li> </ul>	-77		CLEOWS Addree FE				OME. P.A.
ă		JOHN Z.	MERCERON		O S. HARRISC				JIII, 1 11.
clan/Medical Examiner	t	Sequentially list conditions, any, loading to immediate cause. Enter Underlying cause (Disease or injury hat initiated events esulting in death) Last	b. Due to (or as a cons  c. Due to (or as a cons  d.						
Physician/Medio		F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pred 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time o 9 ☐ Unknown	etal death 3[	□Ectopic pregnancy □ Other (specify)		23d.	Date of deliver	y Day Year
2	ר ר	art II. Other significant conditions	contributing to death but not r	esulting in the u	inderlying cause given in Pa		,		e cause of death?
eleted by Physic	-					24a. Wa:	s an 24		sy findings available
2							ormed?	death?	
Completed			γ			1 ☐ Yes	2 <b>1</b> Nó	1 Yes	2 □ No
To Be	2	25. Was case referred to medical examiner? 1	28a. Date of Injury (Month, Day Year)	ER/Outpatie	ont 3 DOA Other: 4 do of other: 4 do	ace of Death (Check only   Nursing Home 5 ☐ Res     28d. Describe	2 1446 one) idence 6 🗆	1 ☐ Yes	
on: To Be	2	examiner? 1 ☐ Yes 2 ☑ No 17. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	nt 3 DOA Other: 4 D  f 28c. Injury at Work?  M 1 Yes 2	1 Yes ace of Death (Check only Nursing Home 5 Res 28d. Describe	2 ANO one) idence 6  how injury oc	1 ☐ Yes : Other (Specify,	
neral director.	2	examiner?  1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury thome, farm, stocify)	nt 3 DOA Other: 4 down of the state of the s	1 ☐ Yes ace of Death (Check only Nursing Home 5 ☐ Res 28d. Describe ☐ No 28f. Location City or To	2 Ario one) idence 6 how injury oc (Street and Nown, State)	1 ☐ Yas :  Other (Specify, curred	Route Number,
ineral director.		examiner?  1	28a. Date of Injury (Month. Day Year) 28e. Place of Injury - Al building, etc. (Spe hysician: To the best of my k miner: On the basis of exam	28b. Time of Injury thome, farm, stocify)	nt 3 DOA Other: 4 down of the state of the s	ace of Death (Check only Nursing Home 5 ☐ Res 28d. Describe ☐ No  28f. Location City or To and place, and due to the death occurred at the time	2 Arto one) idence 6 how injury oc  (Street and Nown, State)  cause(s) and date and plant	1 ☐ Yas :  Other (Specify, curred	Route Number, ited. the cause(s)
pletely filled in by the funeral director. edical Certification: To Be	2	examiner?  1	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - Albuilding, etc. (Spe hysician: To the best of my k miner: On the basis of exam and manner stated.  Completed cause of death (II	28b. Time of Injury  thome, farm, storify)  anowledge, deat ination and/or in the ination and	nt 3 DOA Other: 4 do find 3 DOA Other: 4 do find 3 DOA Other: 4 do find 5 do	ace of Death (Check only Nursing Home 5 ☐ Res 28d. Describe ☐ No  28f. Location City or To and place, and due to the death occurred at the time	2 1 Ario one) idence 6   how injury oc (Street and Nown, State)  cause(s) and date and plate 29d. Date sign	Other (Specify, curred	Route Number, ited. the cause(s)

	-	1 = For State Registrar	State of	Marylar	•	artment of H		Mental Hyg	iene	) 5	10136
		Decedent's Name (First, Middle,	Last)					2. Date of Deat	th		3. Time of Death
Physicia		Dorothy Virginia			Twyman			Day 14	Year 2005	12:00 P M	
/Medica	_	4a. Facility Name (If not institution,		_		4b. City, Town, or		th	4c. Coun	ty of Death	12200
		Julia Manor Hea	1th Care	Center		Hagerst	own		Was	hingt	on
Funeral		5. Social Security Number 6		7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hr	(Month, Day,	Year)	9. Birthp	lace (State or Foreign
Director		214-42-1246	1□M 2XF	77	Yrs.	Monard Buy	110010	Sept. 8	, 1927	Wes	t <sup>'</sup> Virginia
pu s	}	Usual Residence of Decedent  10a. State 10b. County		10c. Cit	ty, Town or Lo	cation				1	0d. Inside City Limits
/anyla	5		naton							,	1 ☑ Yes 2 ☐ No
the N	ect	MD Washi	ngton	П	agerst	10f. Zip Code		1	0g. Citizen of	What Coun	atry?
with Sa or	<u></u>	354 Henry Ave.				21740					, .
death	Completed by Funeral Director	11. Marital Status	12. Was Dece	dent Ever in U	.S. 13. \		ispanic Origin? (	Specify Yes or No- rto Rican, etc.)		ce - Americ	
or Iter	교	1 ☐ Never Married 2 ☐ Marrie	Amed For d 1 ☐ Yes	2 💢 No				rto Rican, etc.)		ack, White,	
Sours a	þ	3   Widowed 4 □ Divorced	If Yes, Give Year or Da	e ites:		☐ Yes 2 No	Specify:		Spec	ity: Bla	ick
netu	etec	15. Decedent's (Specify only highest	Education grade completed)		16a. Deced	ent's Usual Occup-	ation during most of we	orking	16b. Kind of I	Business/Ind	dustry
ithin and ithin	dr.	Elementary/Secondary (0-12)	College (1-	-4or 5+)		kind of work done o OO NOT use retired	)		-		
it, it,		Unknown			Home	maker	40 Markada Na	- /First Middle A		estic	
y late of	Be	17. Father's Name (First, Middle, La	ist)			•		me (First, Middle, M	Maiden Suma	me)	
is 1 and 2 should be filed within 72 hours after death with the Maryland is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mentai Hygiene.  Item 27 is marked other than "neturel", or flems 23a or 28a-f show other treumatic event, the Medical Exeminer must be rollified at	<u></u>	Harry Jenkins  19a. Informant's Name/Relationshi	(Time Print)		10b Mailie	a Addraga /Street	Mary U	nknown Jural Route Number,	City on Town	- Canas Tin	Codel
d 2 st d 2 st fh and 7 is n treun		Carrie Taylor/Da						ambersbur			
Healt Healt ther		20a. Method of Disposition	ugnter	20b. F	-				20c. Location		
permit. Pages 1 Department of H Importent: If ite any injury or ott		1 🛱 Burial 2 ☐ Cremation 3		olale		sition (Name of natory or other place					
it. P.	-	<ul><li>4 □ Donation 5 □ Other (Special Signature of Funeral Service Lie</li></ul>		Res		n Cemete		8/2005   Rest Haver	lagers		
Department Department on the once.		Signature of Full grant Service En	C		16	01 Penns	vlvania	Ave., Hag	runei	ral Ch	ape⊥ ) 21742
		23a. Part1. Enter the disease, or conshock, or heart failure. List or	omplication to the	used the deat						VII , FIL	Approximate
Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Pn Due to (c	eumonia orasa conseq mentia	a						Interval Between Onset and Death
ate be executed hysician and the burial-transit	licai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause to Issues or injury that initiated events resulting in death) Last	c. Hy	Oue to (or as a consequence of):  Hypertension  Oue to (or as a consequence of):						431	
the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death.  the Funeral Director: After this certificate has been signed by the attending physician and npletely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12_months? 1 □ Yes 2 ☑ No 9 □ Unknown		rth 2 ☐ Feta ant at time of d	I death 3	Ectopic pregnancy Other (specify)				ate of delive	ry Day Year
quires that nu signed t	۾	Part II. Other significant condition	s contributing to de-	ath but not res	ulting in the ur	derlying cause give	en in Part I.				e cause of death?
The law requate has been page 2 shoul	Completed							24a. Was ar autops perform 1 \( \text{Yes} \) 2	y ned?	prior to con death?	osy findings available inpletion of cause of
clan: certifica ector, p	Be	25. Was case referred to medical examiner?	Harrison -			- T-		ath (Check only one	22.0		
Physic this c	2	1 ☐ Yes 2 🔀 No			ER/Outpatien		4 M Marshigh	Home 5 Reside			)
ing P	Certification:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date o (Month	f Injury n, Day Year)	28b. Time of Injury	28c. Injury Worl		28d. Describe ho	w injury occu	rred	
tending leath. lor: Afte the fune	cati	2 Accident investiga 3 Suicide 6 Could no	t ho				Yes 2 □ No				
or At fiter of Direct	E	4 Homicide determin	289. Place	of Injury - At hig, etc. (Specif	ome, farm, stre y)	et, factory, office		28f. Location (Str City or Town		ber or Rural	Route Number,
pital ours a sref E			Dharalala T	h h 1	undadas 1			1			
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2.	Medical	(Check only 2   Medical Ex	Physician: To the taminer: On the ba and mann	sis of examina	wiedge, death	estigation, in my or	oinion, death occ	e, and due to the ca urred at the time, da	ate and place,	and due to	the cause(s)
7 4 tr	~	29b. Signature and title of certifier				29c. License		29	9d. Date signe		vay, rear)
/			~~			D0060	1396		3/1	4/05	
5		30. Name and address of person will Farid Murshed M	D 1126	Opal C	t. Hage	erstown,	MD 2174	42			
Stat Registra	_	31. Date filed (Month, Day, Year) MAR 2 4 2005	32. Re	agistrar's Signa	doceth )		v				

Physici		Decedent's Name     Paul	Lee	Thornton	II					2. Date of D Month MARCH	Day,	5, 2ŎŮ	3. Time of Death 9:45A.
/Medic				ve street and number)			4b. City, Town,		n of Death	)	4c.	County of De	
		13225 CATA					CLARKS		las O.4 Hea			ONTGOM	
uneral Director		5. Social Security Nur 217–88–38	363	Sex 7. Ag	ge (In yrs. last I 42	Yrs.	If Under 1 Yea Months Days		ler 24 Hrs. s Min.	8. Date of B (Month, L AUG 19	av. Year)	oni	irthplace (State or Forei Country) .O
A N		Usual Residence of E 10a. State	10b. County		10c. City, To	own or Lo	cation						10d. Inside City Limi
e-f sh	ţċ	Maryland	Montgom	nery	Clar	ksbu	rg						1 □ Yes 2 <b>∑</b> □1
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Importent: if item 27 is marked other then "netural", or items 23a or 28e-f show amportent: if item 27 is marked other then "netural", or items 23a or 28e-f show ampoints or other treumatic event, I'm Maraled Examinat must be retilified at once.  To Be Completed by Funeral Director		10e. Street and Numb					10f, Zip Code					zen of What C	
		13225 Cata	awda Man	or Way	Ever in IIS	13 \	20871	Hispanic	Origin? (S	necify Yes or N		ted Sta	ates nerican Indian,
r, or Item Kariner	oy Fun	1 X Never Married 3 Widowed 4		Armed Forces'	? 1981 to	) 1	Vas Decedent of fYes, specify Cu I ☐ Yes 2 💢 No			o Rican, etc.)		Black, Wh	
n "netural Aedical E	Completed by Funeral	1	15. Decedent's E y only highest gi		1983	Sa. Deced (Give life. L	lent's Usual Occi kind of work don OO NOT use retir	upation e during n ed)	ost of wor	rking	16b. Kii	nd of Busines	
er the	E O	12	dary (0-12)	College (1-40)		hef						taurant	t
d oth event	Be	17. Father's Name (F								ne (First, Midd			
marke	은	Paul I	Lee me/Belationship	Thornton (Type Print)	1:	9b. Mailin	a Address (Stree			Louise			Zip Code)
olth an 27 Is r treu		Bonita L.					i-Lake (				. ,		,
t: if item		20a. Method of Dispo 1 Burial 2 K	Cremation 3	☐Removal from State	Chesa	<sub>tery, cren</sub> ipeak	sition (Name of natory or other pi	ace)	3/18	Date / 2005			or Town, State
Departme Importen any injury once.		21. Signature of Fundamental		ensee		22 T	ry, Inc Name and Add nibadeau	ress of Fa	cility tuary	Servi	e, P	.A.	, Maryland 20910
2 = 6 0			N / V	M( mplications that cause	00956	9.	33 Gist	Ave.	, LOW	er Leve	$\Sigma$	ilver S	Spring, MD
Medical		resulting in death)	777		LTTNOSL	s							
caminer	icai Examiner	Sequentially list condition if any, leading to implement the cause. Enter Under Cause (Disease or in that initiated events resulting in death) Leading in death) Leading in the condition in the cause of the cause o	njury 1	b. Due to (or as	irrhosis s a consequence s a consequence s a consequence	ce of):							
g physician and as the burial-transit	edicai	Cause (Disease or in that initiated events	pregnant nonths?	b. Due to (or as Due to (or as d. Due to	s a consequences a consequences a consequences	ce of):  ce of):  ce of):	Ectopic pregnan				2	23d. Date of d Month	elivery Day Year
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [ ] [ ] 5 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MARCH-Year Beorge C. 6:10 PM TODD 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Johns Hopkins Bayview Center Baltimore 8. Date of Birth
(Month, Day, Year)
Tan. 7, 19 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 **X**M 2□ F 218-16-5826 80 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Dorchester Cambridge 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2107 Hudson Road 21613 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Pace - American Indian Black, White, etc. 1 ☐ Yes 2 No 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) waterman seafood 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Purnell Todd Ophelia Pritchett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Todd wife 2107 Hudson Road, Cambridge, MD 21613 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ⊠Burial 2 ☐ Cremation 3 ☐ Removal from State Dorchester Mem. Park 3/14/05 Cambridge, MD \* 4 ☐ Donation 5 ☐ Other (Specify) Thomas Funeral Home P.A. 21. Signatura of Funeral Service Licensee 22. Name and Address of Facility 700 Locust St., Cambridge, MD 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final UREHIA Necks disease or condition resulting in death) Due to (or as a consequence of): HONTES RENAL FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Advise Anenry 2m. 1 Yes 2 No 3 Probably 4 Unknown gangrene gall I landen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? COPD Ventilator dependent 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one, examiner?

1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Examiner The law requires that the death certificate be executed Records, P.O. Box 68760 Division of Vital or Attending Physician:

transit and physician a use as i attending for use as the by After death. within 24 hours after deat To the Funeral Director: To the Hospital

**Physician** 

/Medical

Examiner

Director

Completed by Funeral

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene.
ans: If item 27 Is marked other than "natural; or Items 23a or 28a-f show ans: If item 27 Is the marked other than "natural; or other traumatic event, Item Madical Explainment in the modified at

Department of Health a Important: If item 27 Is any injury or othar tra once.

Physician

/Medical

Examiner

by Physician/Medical

Completed

2

Certification:

Medical

29a, Certifier

Baltimore, Maryland 21215-0036

Registrar

Gree nou

29b. Signature and title of certifier

30. Name and address of parson who completed cause of death (Item 23a) (Type, Print)

and manner stated.

how

29c. License number D04383

12 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

March 10, 2005 Boy View Coucle 3017

MAR 14 2005

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 9, hard March 2005 10:05 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. Cily, Town, or Location of Death 4c. County of Death Examiner Berlin Nursing and Rehabilitation Ctr. Berlin Worcester 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral ™** M 2□F Months Days Hours Yrs Director 12-22-1921 MD 213-18-1396 Usual Residence of Decedent the Maryland 10c. City. Town or Location 10a. State 10h Counts 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f show other treumatic event, It s Madical Examiner must be notified at 1 Yes 2 □ No Director Berlin MD Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 104 Kenwood Court 21811 US Completed by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1X Yes 2 No |94|If Yes, Give
Year or Dates: |946 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: White 3x Widowed 4 □ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Surveyor Land Survey 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Howard D. Tustin Bertha Mae Hayward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) in and 2
copartment of Health at important: if item 27 is 1
any injury or other treingonce. John Tustin (son) 104 Kenwood Court, Berlin, Md. 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Cape Henlopen Crem. 3-10-05 Frankford, DE ` 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funer Pervice Licensee 22. Name and Address of Facility The Burbage Funeral Home 108 William St., Berlin, Md. 21811 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death atheroscierotic heart Immediate Cause (Final bronary **Physician** month disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner ed by the attending physicien and detached for use as the burial-transit requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown ate has been signed by page 2 should be detach Part IL Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Denknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2170 1 Yes 2 40 1 Yes Hospitel or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Abursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 ANatural 5 Pending death. 1 Yes 2 No investigation 2 Accident after death Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospitel
within 24 hours a:
To the Funerel D 29a, Certifie 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) (OE) C1-0006795 3-10-05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CRISTINE MERIFAN MD 1209 COASTAR MGHWAY, FEMILCE ISLAND, DE 19944 H. Cot 31. Date filed (Month Day 1 1 2005 32. Agistrar's Signature State Registrar

DHMH 17 Rev 1/2001

Richard

Tustin,

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. U 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 10 2005 MARGARET G. VALLIANT March 5:15 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Genesis HealthCare -The Pines Talbot Easton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day Year) FEB 15 1917 7. Age (In yrs. last birthday) 5 Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1□ M 20 F 88 Director MARYLAND 213-01-8346 Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10b County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Examiner must be notified at XXYes 2 □ No Director TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 610 DUTCHMAN'S LANE 21601 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 14. Race - American Indian. 11. Marital Status Black, White, etc. iled within 72 hours after 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: WHITE δ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) BANK TELLER BANKING 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be should be fi BERNARD GUTHRIE NORA MERRICK ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a important: If item 27 Is any injury or other tra BRUCE DUNCAN/PERS. REP. 608 BROOKLETTS AVE., EASTON, MD 21601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION CTR 3/12/2005 STEVENSVILLE, MD permit. 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL
200 S. HARRISON ST EASTON, MD 21601 21. Signature of Funeral Service Licensee HOME PA 05cp4 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician weeks /Medical Examiner Coquentially list cultures, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit be executed attending physician and Due to (or as a consequence of): Box 68760, Physician/Medical use as the IF FEMALE If yes, outcome of pregnancy
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1 Yes 2 No 24a Was an certificate has autopsy performe Yes Jeepooris 1 Yes funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner's 32No Hospital: Other: 5 Residence 6 Other (Specify) 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? Hospital or Attending PI
 hours after death.
 Funeral Director: After the 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Natural Injury 5 Pending 1 □ Yes 2 □ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospital within 24 hours a To the Funeral C 29a. Certifier 🔫 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MICHAEL State 1 5 2005 Registrar

Margaret Valliant

			For State Registrar	State of	Maryland / Dep Ce	artment of F ertificate of	lealth and Death		gien <del>e</del> 005 Reg. No.	10141
	Physici		Decedent's Name (First, Middle Elsie	S.	Ward			2. Date of De Month March	Day Yea 5, 2005	3. Time of Death
	/Medio Examin		4a. Facility Name (If not institution	, give street and numb	ber)	4b. City, Town, o	or Location of Dea		4c. County of De	
			Alfred House				Spring		Montgom	
г	Funeral		5. Social Security Number	6. Sex 7 1 ☐ M 2 🔀 F	. Age (In yrs. last birthda)	Months Days	If Under 24 Hr Hours Mir	n. (Month, Da	y, Year)	lirthplace (State or Foreign Country)
	Director		577-38-6899 Usual Residence of Decedent		90 Yrs.			Dec. I	2, 1914 M	aryland
	yland		10a. State 10b. County		10c. City, Town or I	ocation				10d. Inside City Limits
	a-f st	ctor	Maryland Mon	tgomery	Silve	r Spring				1 ☐ Yes 24 ☐ No
	ith the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
	ath w		2804 Hewitt			2090			USA	
	er de	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marr	Armed Ford	es?	. Was Decedent of H If Yes, specify Cub	dispanic Origin? an, Mexican, Pue	(Specify Yes or No orto Rican, etc.)	14. Race - Ar Black, Wi	nerican Indian, nite, etc.
36	irs aff	by F	3 ₩ Widowed 4 Divorced	If Yes, Give Year or Dat		1 ☐ Yes 2 ☑ No	Specify:		Specify: Wh	ite
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7	lled w tygier her th		17. Father's Name (First, Middle,	( a et )	Но	memaker	18 Mother's N	ame /Firet Middle	Own Hom Maiden Surname)	e
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lary	and N		19a. Informant's Name/Relations	hip (Type, Print)	19b. Mai	ling Address (Street	and Number or I	Rural Route Numb	er, City or Town, State	. Zip Code)
	of Health Itam 27 i		Betty J. Haley	/ Daughter			Avenue,		pring, MD	
altimore,	or off		20a. Method of Disposition 1 → Burial 2 → Cremation			position <i>(Name of</i> Amatory or other pla Memorial Pa	rk	ch 9,	20c. Location - City of	or Town, State
莊	Par Tight		<ul><li>4 □ Donation 5 □ Other (S</li><li>21. Signature of Funeral Service</li></ul>				2	2005		, Maryland
Ba	permit. Departr Imports any inju		MillEd			Francis J 500 Unive	. Collings	ıs Funera .vd, W, S	l Home Inc ilver Spri	ng, MD 20901
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that car only one cause on ear	used the death. Do not e ch line.	nter the mode of dyi	ng, such as cardi	ac or respiratory a	rrest.	Approximate Interval Between Onset and Death
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ion	Attanding F r death. actor: After by the funer	atlor	1 XNatural 5 ☐ Pendir 2 ☐ Accident investi		, Day Year) Injury	Wo	rk? ]Yes 2 □ No			racificy
Division	or Attandii after death. Diractor: Ai in by the fu	Certification:	3 Suicide 6 Could 4 Homicide determ	ined 286. Place	of Injury - At home, farm, s g, etc. (Specify)	treet, factory, office	-	28f. Location ( City or To	Street and Number or I	Rural Route Number,
Ö	ital or A irs after ral Dirac led in by									
	To the Hospital or At within 24 hours after or To tha Funaral Dirac completely filled in by	edical	29a. Certifier 1 ☐ Certifyir (Check only one) 2 ☐ Medical	ng Physician: To the b Examiner: On the bas and manne	pest of my knowledge, dea sis of examination and/or er stated.	ith occurred at the ti nvestigation, in my o	me, date and pla opinion, death oc	ce, and due to the curred at the time,	cause(s) and manner date and place, and d	as stated, ue to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifie		ilass in	29c. Licens	se number		29d. Date signed (Mo.	nth, Day, Year)
	60		· Chica-	1 Call	The state of the	D2:	5410		March 8,	2005
			30. Name and address of person				L171 5		MD 000	2.0
			Oliver James 31. Date filed (Month, Day, Year)				nilip Dr	ive, Oin	ey, MD 208	32
	Sta Regist		MAR 0 9	2005	gistrar's Signature	perli				

			1 - State Registrar	e of Maryland / De	partment ertificate	of Health an		iene 005	10142
E	Physici		1. Decedent's Name (First, Middle, Last)  James Price	Welch			2. Date of Deat Month March	Day Yea 3 2005	3. Time of Death 12:35PM
	/Medic Examin		4a. Facility Name (If not institution, give street and	i number)	4b. City, To	own, or Location of D		4c. County of De	
145	Lamin		Wicomico Nursing	Home	Sa	lisbury		Wicom	ico
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthd		Year If Under 24	Hrs. 8. Date of Birth		
	Director		579-18-5856 <sup>1⊠M 2□</sup>	F 84 Yrs	Months	Days Hours M	Min. (Month, Day, Sept. 5	,1920 Wa	tirthplace (State or Foreign Country) ashington, DC
	pu ,		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or					1011-11 05 11 5
	sho	ř	261						10d. Inside City Limits 1⊠ Yes 2 ☐ No
	28a-f	ecto	Md • Worcester	Ber1		Na da		On Chinas of Miles	
	a or	급	17 N. Pintail Drive		10f. Zip C	21811	'	og. Citizen of What USA	Country?
	filed within 72 hours after death with the Maryland Hygiens ther than "natural", or items 23s or 28s-f show ent, it a Medical Examination notified at	Funeral Director	100 111	Decedent Ever in U.S. 1			? (Specify Yes or No-		nerican Indian,
(0	r iten	Fun	1 Never Married 2 Married 1 M	de Forces? 1945— es 2 Not 945— is, Give or Dates: 1953—			? (Specify Yes or No- uerto Rican, etc.)	Black, Wi	
ဗ္ဗ	ours a	by	3 ☐ Widowed 4 ☐ Divorced   If Yes	s, Give 1951 – or Dates: 1953	1 ☐ Yes 2	△ No Specify:		Specify:	White
21215-0036	72 hc	Completed	15. Decedent's Education (Specify only highest grade comple	16a. De	cedent's Usual	Occupation	working	16b. Kind of Busines	ss/Industry
7	ithin ne. nen.	npl		ge (1-40r5+)		done during most of retired)		Dotont I	orr Edward
7	led w lygier her tt	S		F L	awyer	40.14.1		Patent La	aw Firm
and But	be fill H	Be	17. Father's Name (First, Middle, Last)  John Clarence Welch				Name <i>(First, Middl</i> e, <i>M</i> izabeth Mo:	•	
Ĕ	d Mer d Mer nerk	၀	19a. Informant's Name/Relationship (Type, Print,	10h M	siling Address /		r Rural Route Number		7-0-4-1
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Any injury or other traumatic event, tra Medical Examinar must be multied at once.	1	Theresa Wolff Welch/Wi				erlin, Md.	-	, Zip Code)
6	Heal Heal tem 2		20a. Method of Disposition	20b. Place of Discemetery, of				20c. Location - City	or Town, State
Baltimore,	yor V		1 Burial 2 □ Cremation 3 □ Removal f	UIII State		<sup>ler place)</sup> ¦Ma letery ∣20		Pockwille	, Maryland
量	artme ortan injur		21. Signature of Euneral Service Licensee	20	-	-	DeVol Fune:		, Maryrand
മ്	Den Imp	A 3	hour Stalle		2222 Wi	sconsin A	ve.,NW.,Wa	shington.	DC 20007
5			23a. Part1 Enter the disease, or complications to shock, or heart failure. List only one cause	at caused the death. Do not					Approximate Interval Between
age .	Physician		Immediate Cause (Final disease or condition	ILURE 1	o Ti	10111=			Onset and Death
	/Medical		resulting in death)	to (or as a consequence of):	<i>U</i> /h	1/2100		~	
	Examiner		Sequentially list conditions	LZHEIMERS		DEMEN	TIA		
21	D ==	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	e to (or as a consequence of):					
	and and -trans	kam	that initiated events	e to (or as a consequence of):					
8760,	sate be executed hysicien and the burial-transit	al E	50	o to (or as a consequence or).					
387	death certificate be executed e attending physicien and ed for use as the burial-transit	edical	d						
Box 6	death certifica attending ph for use as t	√Me	IF FEMALE: 23c. If yes 23c. If yes	, outcome of pregnancy				23d. Date of d	elivery
ă	death a atter	Physiclan/M	in the nast 12 months?		3 □Ectopic preg 5 □ Other (spec			Month	Day Year
<u>о</u> .	that the de led by the detached	hys	9 Unknown 9 U	nknown					
<u>ر</u> ر	res tha iigned l be det	by P	Part II. Other significant conditions contributing	to death but not resulting in the	e underlying cau	use given in Part I.	23e. Did tob	acco use contribute	to the cause of death?
Records,	w require been sig should b	edk	GOUT				1 ☐ Ye	s 2 □ No 3 □	Probably 4 TUnknown
00	e law re has be je 2 sho	plet	ANEMIA				24a. Was ar		autopsy findings available completion of gause of
Ě	or Attending Physician: The law requires that the third death. Director: After this certificate has been signed by the in by the funeral director, page 2 should be detached.	Completed					perform	ned? death'	2
İta	sian: artifica ctor,	Be (	25. Was case referred to medical examiner?				Death (Check only one	9)	
Ž	hysic his co	2	1 ☐ Yes 2 ☑ No Hospital:		tient 3 DOA		ig Home 5 ☐ Reside	nce 6 Other (Sp	pecify)
Ü.	ing P	lon;	Talifatara 5 1 origing	late of Injury 28b. Time Month, Day Year) 28b. Time Injur		c. Injury at Work?	28d. Describe ho	w injury occurred	
isi	ttend death stor: ,	lcat	2 Accident investigation 3 Suicide 6 Could not be	lace of Injury - At home, farm,	M Street featen	1 Yes 2 No	29f Location (St	root and Alumbar or	Rural Route Number.
Division of Vital	or Attend after death Director:	Certification;	4 Homicide determined 259.	uilding, etc. (Specify)	street, ractory, t	onice	City or Town		nurar noute rumber,
	spita tours neral		29a. Certifier 1 Certifying Physician: To	the best of my knowledge, de	eath occurred at	the time, date and pl	ace, and due to the ca	use(s) and manner	as stated.
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: Atter this certificate h completely filled in by the funeral director, page	edical	(Check only 2 Medical Examiner: On t	ne basis of examination and/or manner stated.	investigation, in	n my opinion, death o	ccurred at the time, da	ite and place, and di	ue to the cause(s)
	To the To the Comp	×	29b. Signature and title of certifier		29c. l	License number	29	d. Date signed (Mo	nth, Day, Year)
	3+1		1 Mahertar 1	MD	D	-0060	515	3/3/0	5.
	/11		30. Name and address of person who completed	, , , ,				111	
			Mahesha Thimmaraya	opa M.D. 61	4 East	ternshor	e Drive S	alisbur	y 21804
	Sta Registr		31. Date filed (Month, Day, Year) MAR 0 9 2005	2 Registrar's Signature	barle				

JAMES MERCH

			1- For State of Maryland / Department	artment of Health and M rtificate of Death		ene 005	10143			
	Physicia	an	Decedent's Name (First, Middle, Last)		Date of Death     Month	Day Year	3. Time of Death			
	/Medic	al	EMMA JEAN WRIGHT	4b. City, Town, or Location of Death	Mar	4c. County of Death	6:40 Pm			
	Examin	er	4a. Fecility Name (If not institution, give street and number)  Holy Cross Hospital	Silver Spring	ſ	Montgom				
-	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day,	9. Birth	place (State or Foreign			
	Director		247-24-6711 <sup>1□M</sup> 発射 88 Yrs.	Months Days Hours Mill.	Dec 18	1916 5.	Carolina			
	and w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Lo	cation			10d. Inside City Limits			
	Maryl -f sho	tor	Md Prince George Fort Wa	ashington			14 Yes 2 No			
	r 28e	irec	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Cou	intry?			
	23a o	raiD	6801 Bock Rd, #118	20744		U.S.A.				
က	within 72 hours after death with the Maryland ene. than "naturel", or Items 23s or 28e-f show fre M. steel Examble to unit be mailfied at	Funeral Director	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 25 ☐ No	Was Decedent of Hispanic Origin? (Sp f Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White				
ğ	ours a	d by	3 Vidowed 4 □ Divorced If Yes, Give Year or Dates:	1 ☐ Yes <b>XIX</b> No Specify:		Specify: B1	ack			
7	"natu	iete	15. Decedent's Education 16a. Deced (Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	ing 1	6b. Kind of Business/N	ndustry			
21215-0036	d withir giene. ir than	Completed	Flamentary/Secondary (0-12)   (College (1-4015±)	Cook		Privat	e			
힏	be file tal Hy d othe event,	BeC	17. Father's Name (First, Middle, Last)		e (First, Middle, M	,				
Sla	1 Men narke	1º	London Duckett			?	On the l			
Maryland	id 2 st th and th sun traun			ng Address <i>(Street and Number or Run</i> 0 Aragona Blvd						
	s 1 an f Heal item ?		20a. Method of Disposition 20b. Place of Dispo			Oc. Location - City or T				
Ë	Page nent o ant: M		Donation 5 ☐ Other (Specify)  3 ☑ Removal from State  Va ☐ Donation 5 ☐ Other (Specify)	n Mem Grds 3/12	2/05	Norfolk,	VA			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or items 23a or 28e-f show any injury or other traumatic event, fre Modical Examinet is ust be multilled at once.	(		Name and Address of Facility Sno 46 N Washington						
			23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death			
	Physician		Immediate Cause (Final disease or condition resulting in death)  SEPTICEMIA a				Onset and Death			
Н	/Medical Examiner		Due to (or as a consequence of):  ACUTE RENAL FAILURE							
		er	Sequentially list conditions, depression of the sequence of th	TATHORE						
	cuted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  SWAL-LOWING D	YSFUNCTION						
90,	icate be executed physicien and s the burial-transit		resulting in death) Last Due to (or as a consequence of):							
68760,	icate b physic	dica	d							
Box (	eath certific attending pl	n/Me	IF FEMALE: 23c. If yes, outcome of pregnancy	75-1		23d. Date of deliv	rery			
O. B	that the death ted by the atter detached for u	Physician/Medical		Ectopic pregnancy Other (specify)		Month	Day Year			
۵.	that the ed by detacl		Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?			
rds	sigr sigr d be	ed by			1 ☐ Yes	2 □No 3 □ Pro	bably 4 Knknown			
eco	e faw requ has been je 2 shouli	Completed			24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of			
E H	Thate page				performe 1 ☐ Yes 26	ed? death? No 1 ☐ Yes	2 No			
Z:E	Physicien: Th r this certificate ral director, pag	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2X No  Hospital: 1 X Inpatient 2 ☐ ER/Outpatien	Othor	h (Check only one,	ce 6 Other (Speci	Z.1			
of	g Physer this	<b> -</b>	27. Manner of Death 28a. Date of Injury 28b. Time of	IL 3 DOX 4 INdising Flo	28d. Describe how		ry)			
Sior	Attending I r death. ector: After by the funer	atio	2 Accident investigation	M 1 Yes 2 No						
Division of Vital Records,	l or Attenuation death	Certification:	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (Stre City or Town,	et and Number or Rui State)	al Route Number,			
	To the Hospital or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	edical C	29a. Certifier (Check only one)  1 **Certifying Physicien: To the best of my knowledge, deatled.  2 **Medical Examiner: On the basis of examination and/or in and manner stated.	n occurred at the time, date and place, vestigation, in my opinion, death occur	and due to the cau red at the time, dat	se(s) and manner as e and place, and due	stated. to the cause(s)			
	To th within To th	Me	29b. Signature and title of certifier	29c. License number	290	d. Date signed (Month,	Day, Year)			
	5		Connule, NO LE, COM	D60619		March 8,	2005			
			30. Name and address of person who completed cause of death (Item 23a) (Type, Connie Le, MD 1500 Forest Gler	n Road, Silver	Spring	MD 2090	6			
	Sta	te	Connie Le, MD 1500 Forest Gler  31. Date filed (Month, Day, Year)  Registrar's Signature	M.	75- TIIA 1	110 2000				
	Registr		31. Date filed (Month, Day, Year) MAR 0 9 2005  Registrar's Signature							

			For 1_ State	State of Maryland	d / Depa	artment of I	Health and i	•	•	TO LLI
			Registrar		Ce	rtificate of	Death	1	eg. No. UU	10144
	Physici	an	<ol> <li>Decedent's Name (First, Middle, L John Frederick</li> </ol>					2. Date of Dea Month	th Day Year	3. Time of Death
	/Medic		4a. Facility Name (If not institution, gi			4b. City. Town. o	or Location of Deat	MARCH	4 2005 4c. County of Dea	7:25 2
	Examin	er	St. Mary's Hos				ardtown	•	St. Ma	
F	uneral		Social Security Number 6.	Sex 7. Age (In yrs. la	ast birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day)		rthplace (State or Foreign country)
D	irector		578-30-8112 Usual Residence of Decedent	1ŒM 2□F 78	Yrs.	Months Days	Hours Min.	Oct 24	,1926 Was	hington, DC
with the Maryland	Now		10a. State 10b. County	10c. City	, Town or Lo	ocation				10d. Inside City Limits
e Ma	r 28a-f ehow rotified st	ctor	Maryland St.	Mary's C	harlo	tte Hall				1 ☐ Yes 21 No
iji th	0 99	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What C	ountry?
	230 ILEST &		29449 Charlot	.,			0622		USA	
er de	item ner n	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	5. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puerl	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Whi	ite, etc.
Maryland 21215-0036 at 2 shouts be filed within 72 hours at the and Markel Hydiene.	I, or	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🖾 Divorced	1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1941	-45	1 ☐ Yes 2 ☑ No	Specify:		Specify: Wh	ite
<b>5-0036</b> 72 hours after death	ature cul E	ted	15. Decedent's E	ducation	16a, Dece	dent's Usual Occu	pation		16b. Kind of Business	s/Industry
1215 within 7	Madi	ple	(Specify only highest g. Elementary/Secondary (0-12)	rade completed)  College (1-4or 5+)	(Give life.	kind of work done DO NOT use retire	during most of world)	king	Maryland	
21 Page 1	othar then	Completed	12		Real 1	Estate Ri	ight-of-W	ay Agent	Road Com	mission
		Be	17. Father's Name (First, Middle, Las John Henry Wo					ne (First, Middle, I		
ylan	marked matic ev	2		-tel statement				n Isabel		
Mar 12 sh	If item 27 is marked or other treumatic e		19a. Informant's Name/Relationship						City or Town, State,	
a, -	m 27		Richard A. Worm  20a. Method of Disposition		1892	Brittany	Lane, S			, WA 98512
O See	= 5		1 Burial 2 ☐ Cremation 3	_Intellioval Hotel State	metery, crei	esition (Name of matory or other pla	ce) Mar	19, 19,	20c. Location - City or	r Iown, State
Baltimore,	rtent njury		<ul><li>4 □ Donation 5 □ Other (Spec</li><li>21. Signature of Funeral Service Liggs</li></ul>	1 00		ill Cemet		005	Suitland, M	aryland
Ba med	Importent: If its eny injury or or once.		11. Signature of Fulleral Service Lite	The contract of the contract o					Home Inc	
			23a. Part1. Enter the disease, or cor	nplications that caused the death.	<u>  5 (</u>	00 Univer	sity Blvo	or respiratory arre	Lver Sprin	g, MD 20901 Approximate
Di			shock, or heart failure. List only Immediate Cause (Final	y one cause on each line.		/		or roop natory and		Interval Between Onset and Death
	/sician ledical		disease or condition resulting in death)	a	phemo	MA / Sej	1311			
	aminer			Due to (or as a consequ	ence or):					
		ē	Sequentially list conditions, tany, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequ	eries offic					
cuted	nd ransit	Examiner	that initiated events	a Devention						
60, be executed	sician and burial-transit		resulting in death) Last	Due to (or as a consequ	i .					
E =	~ 0	ical		d. Hd of St	troke					
. Box 68 death certifica	attending phy for use as th	Physiclan/Med	IF FEMALE:							
Box	ttend or us	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal	death 3□	Ectopic pregnanc	у		23d. Date of de Month	livery Day Year
<b>ं</b> हैं	by the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of de 9□ Unknown	ath 5□	Other (specify) _			, , , ,	buy rear
<u> </u>	ed by detac	Ph	Part II. Other significant conditions	contributing to death but not resul	lting in the u	nderlying cause gr	ven in Part I	23e Did toh	pacco use contribute to	o the cause of death?
Vital Records, P.O sicien: The law requires that the	De pe	0	• • • • • • • • • • • • • • • • • • • •			indonying dadoo gii	TOTAL TOTAL			robably 4 □Unknown
S V Tequ	been s	ete								
Rec The law	has je 2	Completed						24a. Was ar autops perforn	y prior to	utopsy findings available completion of cause of
<u>a</u>		e Co	25. Was case referred to medical					1 ☐ Yes 2	PØNo 1□Yes	3 2 □ No
of Vita		00	examiner?	Hospital: 1 Inpatient 2 E	R/Outpatien	nt 3 DOA Oth		th (Check only on		
	두 공	n; To	27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Inju	ry at	28d. Describe ho	nce 6 Other (Spe	ену)
VISION Attending	r: After e funer	atio	1 □ Natural 5 □ Pending 2 □ Accident investigation	(Month, Day Year) on	Injury	M 1	rk?  Yes 2 □ No			
Division for Attending	acto by th	ific	3 ☐ Suicide 6 ☐ Could not determined		ne, farm, str	eet, factory, office		28f. Location (Str	reet and Number or R	ural Route Number,
tal or	lerel Diractor: filled in by the	Certification;		Dunding, atc. (apacity)				City or Town	, Jiaio)	
DIVISIO To the Hospital or Attendi	Funer ely fill	edical (	(Check only 2 Medical Exa	hysician: To the best of my know miner: On the basis of examinati	rledge, death	n occurred at the til	me, date and place	, and due to the ca	tuse(s) and manner as	s stated.
the I	To the Fun completely	Medi	une)	and manner stated.		29c. Licens				
To	2 8	-	29b. Signature and title of certifier	V/M 60973			006047		Od. Date signed (Mont	
10	+1		IN DIMINIO	TOOL -			000017	9	03/04/20	
			30. Name and address of person who			'				
	Sta	to	MEHRDAD AKHLAGH  31. Date filed (Month, Day, Year)	I ST. MARYS H	USPITA	L LEONAR	DTOWN MD	20650		
<b>₩</b> .₩	Sta Registra		MAR 0.9 2	nns Pergue B	C BO	BACK!				

JOHN F WORMCKE

		. 101	artment of Health and Mental	
		Ragistrar	rtificate of Death	Reg. No UUU UUU
Physic /Medi		1. Decedent's Name (First, Middle, Last) Evelyn Mae Collins Akery	Marc	ch 19 2005   3:30p M
Exami	ner	4a. Facility Name (If not institution, give street and number) 805 Wicklow Road	4b. City, Town, or Location of Death Baltimore City	4c. County of Death
Funeral Director		5. Social Security Number 213-26-7422 6. Sex 7. Age (In yrs. last birthday, 76 Yrs.	If Under 1 Year   If Under 24 Hrs.   8. Date   Months   Days   Hours   Min.   Oct	of Birth nth, Day, Year) 9. Birthplace (State or Foreign Country) Md
Maryland -1 show	tor	Usual Residence of Decedent  10a. State		10d. Inside City Limits 1 ∰Yes 2 ☐ No
h with the 23a or 28a	ai Director	10e. Street and Number 805 Wicklow Road	10f. Zip Code 21229	10g. Citizen of What Country? USA
J36 us after deal si, or items;	by Funeral	3 Widowed 4 Divorced Year or Dates:	Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, e 1 ☐ Yes 2 ☐ No Specify:	s or No- ltc.) 14. Race - American Indian, Black, White, etc. Specify: black
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 ie merked other than "natural", or Items 23a or 28e-1 show any injury or other treumatic event, the Medical Eventual that Inditited at once.	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)  12  16a. Deceding (Give life.)  W	dent's Usual Occupation kind of work done during most of working DO NOT use retired) aitress	16b. Kind of Business/Industry food service
/land /	To Be C	Ctarline Collline Cr	18. Mother's Name (First, Marjorie She	
Mary nd 2 sho lth and h 27 is ma	ľ	19a. Informant's Name/Relationship (Type, Print)	ng Address <i>(Street and Number or Rural Route</i> Bartholow Rd., Sykesv	
ges 1 ar of Hea if Item or other		20a. Method of Disposition  20b. Place of Disposerementary, creating a superior of the superio		20c. Location - City or Town, State
Baltimore, permit. Pages 1 ar Department of Hea Important: if Item any injury or other once.		21. Signature of Funeral Service Licensee 22	will Memorial   3-24-05 2. Name and Address of Facility Haight .0. Box 195 Eykesville	
		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac or respira	The state of the s
Physician /Medical Examiner		disease or condition resulting in death)  a. Due to (or as a consequence of):	Sim	THE STATE OF THE S
uted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	poidism	
68 / 60, ificate be executed 7 physician and as the burial-transit	cai	(d		
BOX ath cert	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 manths? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ 4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown	□Ectopic pregnancy □ Other (specify)	23d. Date of delivery  Month Day Year
rds, F.C. quires that the densigned by the auld be detached in	b	Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I. 23e	Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown
	Completed			. Was an autopsy performed?  Yes 2 1 No 1 Yes 2 No
Ita clen:	Be (	25. Was case referred to medical examiner?	26. Place of Death (Check	only one)
of ysi	2	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien		Residence 6 Other (Specify)
SION OT VICAL Ke tending Physiclen: The I beath. for: After this certificate ha the funeral director, page	tlon:	27. Manner of Death 1	f 28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No	scribe how injury occurred
LIVISION OT VITA  Hospitel or Attending Physicien: 4 hours after death. Funeral Director: After this certificatiely filled in by the funeral director, tely filled in by the funeral director,	Certification;	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, structure building, etc. (Specify)	reet, factory, office 28f. Loca	ation (Street and Number or Rural Route Number, or Town, State)
LIVI  To the Hospitel or At within 24 hours after or To the Funeral Direct completely filled in by	edical C	29a. Certifier (Check only one)  1. Certifying Physician: To the best of my knowledge, deat one)  1. Certifying Physician: To the best of my knowledge, deat one)  2. Medical Examiner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place, and due vestigation, in my opinion, death occurred at the	to the cause(s) and manner as stated.  time, date and place, and due to the cause(s)
To the I within 2. To the I complet	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
SA		30. Name and address of person who completed cause of death (Item 23a) (Type,	V0053981	2164 163
St	ate	31. Date filed (Month, Day, Year)  MAR 2 5 2005  3 Registrar's Signature	112	
Regist		MAR 2 5 2005  Registrar's Signature	wee .	

			1 - For State Registrar	State of Marylan		artment of H <i>rtificate of L</i>			iene () ( eg. No.	05	10146
	Physici	an	1. Decedent's Name (First, Middle, L		-			2. Date of Deat Month	h Dav	Year	3. Time of Death
	/Medic	al	MARY ANN 4a. Facility Name (If not institution, g	ROBERTS ALLI	EN	4h City Tourn or	Location of Death	MARCH		2005 by of Death	6:15P M
	Examin	er	5009 DENMORE			-	MORE CI	TY	N/Z	-	
	Funeral			Sex 7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthpi Coun	lace (State or Foreign
	Director		214-84-0453 Usual Residence of Decedent	43	TTS.			07/13/	1961	MARY	YLAND
	aryland show		10a. State 10b. County  MD N/A		y, Town or Lo					10	0d. Inside City Limits
	the Ma 28a-1	Director	MD N/A		BALTI	MORE CIT	Ϋ́				Mo 2 □ No
	death with the Maryland ms 23a or 28a-f show roust be notified at	Dir	5009 DENMORE	AVENUE		10f. Zip Code 2121	E		0g. Citizen of	What Coun	try?
	r deati	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	.S. 13.	Was Decedent of Hi If Yes, specify Cuba			USA 14. Ra	ce - America	an Indian,
36	a within 72 hours after death with the Marylar Jiene. rthen "naturel", or items 23a or 28a-4 show The Madical Examiner must be notified at	by Fu	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes XXNo If Yes, Give Year or Dates:	ì		Specify:	, , , , , ,		か: BLA	
215-0036	72 hou nature ical E	ted	15. Decedent's (Specify only highest g	Education	16a. Dece	dent's Usual Occupa	ition		16b. Kind of E	Business/Inc	dustry
	within 72 ane. then "nai	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done a DO NOT use retired,	unng most or worki )	DISABILITY			
Q Z	Hyg Hyg ant,	e Co	12TH 17. Father's Name (First, Middle, Las	2 ÝÉARS	DIS	SABILITY	18. Mother's Name	e (First, Middle, N			Y
/land		To Be	LLOYD ROBI	ERTS			VERNE]	LL WII	LIAMS	3	
Mar	2 should and Men is marke reumatic	·	19a. Informant's Name/Relationship			ng Address (Street a					
ຜົ	s 1 and 2 should if Health and Mer item 27 is marke other treumatic		TYRONE ALLEN A	20b. P	lace of Dispo	DENMOR			IMORE 20c. Location		
Baltimor	9° = 5		1   Burial 2 □ Cremation 3  4 □ Donation 5 □ Other (Spec	Themoval irom State   T C	emetery, crer DUDON	natory or other place PARK CE	M.   3/28		BALTIM		
Salt	permit. Pag Department Importent: any injury o		21. Signature Funeral Service Lic	en		. Name and Addres					
Ц	#05 # 3		23a Party, Enter the disease, or co	1 Tally						BALTI	MORE, MD
			Immediate Cause (Final	mplications that caused the teat ly one cause on each line	i. Do not ent				est,		Approximate Interval Between Onset and Death
	Pnysician /Medical		disks e or condition resulting in death)	aOnges Due to (or as a conseq	t, ve uence of):	Heart	Failure	2		-	
	Examiner		Sequentially list conditions.	b							
	ted sit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Uncertying Cause (Disease or injury	Due to (or as a consequence	uence of):						
ĵ	execu in and ral-tra	Examiner	that initiated events resulting in death) Last	c. Due to (or as a conseq	uence of):						
09/90	tificate be executed g physician and as the burial-transit	edical		d							
ŏ X O			IF FEMALE:	23c. If yes, outcome of pregna	ncv		-				
<u> </u>	death cer e attendir id for use	Physician/N	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	death 3	Ectopic pregnancy Other (specify)				ate of deliver onth	ry Day Year
5	at the I by the	Phys	9 Unknown	9□ Unknown							
Š,	signed	by	Part II. Other significant conditions  Esophag	4.1 -	alting in the u	nderlying cause give	n in Part I.	23e. Did tob			e cause of death?
ecords	w requ	letec	Anglino	. , , ,				24a. Was ar			esy findings available
	hystoien: The law requires that the his certificate has been signed by th i director, page 2 should be detache	Completed	TITIEMIC	,				autopsy perform	red?	prior to comdeath?	rpletion of cause of
VIII O		BeC	25. Was case referred to medical examiner?				26. Place of Death			1 1 1 6 3	E 140
5	<u>n</u> = n	2	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 2 28a. Date of Injury	ER/Outpatien	t 3 DOA Othe	4 LI Nursing Hor	me 5 Resider			)
0	nding ath. r: After e fune	ation	1 Natural 5 Pending 2 Accident investigati	(Month, Day Year)	Injury	Work	? es 2 □ No	Edd. Describe No	w injury occur	ieu	
JIVISION	r Atter	Certification;	3 ☐ Suicide 6 ☐ Could not determine		ome, farm, str	et, factory, office	2	28f. Location (Str City or Town,	eet and Numi State)	ber or Rural	Route Number,
ב	pitel o		On Ontification								
	To the Hospitel or Attending Physicien: which 24 hours after deals. To the Funerel Director: After this certification in the funerel birector. completely filled in by the funeral director.	edical	29a. Certifier 1 Certifying F (Check only one) 2 Medical Exa	Physician: To the best of my kno aminer: On the basis of examinal and manner stated.	tion and/or inv	estigation, in my op	inion, death occurre	ed at the time, da	te and place,	and due to	the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	c. D		29c. License	number	29	d. Date signe	dj(Month, D	ay, Year)
	1		Kobert 1.	0000	10	_ \\ \D	34851		5/24/	2005	
	9		30. Name and address of person who Robert T Chou	3	23a) (Type,	29c. License  Delvedera	Ave	Balto	nove,	MD	21215
	Sta		31. Date filed (Month, Day, Year) MAR 2.5	32. Registrar's Signa	ture	and a	· · · · · · · · · · · · · · · · · · ·				
	Registra	all	minin & J	LUUS SCHOOL S	1	nd?					

			State of Maryland / De	partment of Health and M	•	•	1011.7
				ertificate of Death	Reg	No:	10177
	Physici	an	1. Decedent's Name (First, Middle, Last) Dorothy Elizabeth Brown		2. Date of Death Month	Day Year	3. Time of Death
	/Medic	cal	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	03	7 2005 4c. County of Deat	1111
	Examir	ięr	GOOD SAMARITAN HOSPITAL	BALTIMORE, MI	N -21239	•	ORE CITY
5;	Funeval		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year   If Under 24 Hrs.	8 Date of Birth		
	Funeral Director		213-36-8232 1 M 2 F 86 Yrs.  Usual Residence of Decedent	Months Days Hours Min.	Month, Day, Y Nov. 15	,1918 Ma	hplace (State or Foreign buntry) ryland
and	Mo #		10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
Ma SeM	28a-1 show	ctor	Maryland N/A Balti	.more			XX□Yes 2□No
1215-0036 within 72 hours after death with the Marvland	iii. 1 agos I am 2 should be doo and while it is in the respiration of the should be a sho	Funeral Director	10e. Street and Number 4404 Craddock Avenue	10f. Zip Code 21212	10g	Citizen of What Co	ountry?
dead	Items 2	nere	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ame	
9	or Ite	Ē	1 Never Married 2 Married 1 Yes, Give	1 Yes 2 No Specify:	rican, etc.)	Black, Whit	
003	Exe.	d b	3 _4 Widowed 4 _ Divorced Year or Dates:			Specify: 2 1	
21215-0036	nati	Completed by	15. Decedent's Education 16a. De (Specify only highest grade completed) (G.	cedent's Usual Occupation ve kind of work done during most of work b. DO NOT use retired)	ing 16	b. Kind of Business/	Industry
12	han a	п	Elementary/Secondary (0-12) College (1-4or 5+)				
ี ด	Hygie ther nt,		7th grade   Dome	estic 18 Mother's Name	e (First, Middle, Ma	rivate f	amily
Maryland	and Mental Hygiene. Is marked other than aumatic event, Ita M	To Be	William Williams		ne Will:		
lar.	ls m		L	ciling Address (Street and Number or Rus			
_ 9	item 27 l		<u> </u>	B Chipper Road B			
O C	If its		cemetery c	rematory or other place) emorial Park 3/2		c. Location - City or	
	tant:		+ Bonation o Bother (opeany)				17
Baltimore,	Department of He Important: If item any injury or other once.		21. Signature of Funeral Service-Licensee	22. Name and Address of FacilityCha 5240 Reisterstow	r Rd Bal	rris Fun ltimore,	Md21215
20			23a. —11. Enter ne disease, or complications that caused the death. Do not a shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arrest	en eze et ankv.	Approximate Interval Between
PI	hysician		A CONTRACTOR OF THE PROPERTY O	HEART FAILURE			Onset and Death
	/Medical		resulting in death)  Due to (or as a consequence of):				
E	xaminer		Sequentially list conditions b. RENAL FA	ILURE			
70	· +	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				
Scute S	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):	PDIOMYOPATHY			
760,	ysician and e burial-transit	<u> </u>	resulting in death) Last Due to (or as a consequence of):				
- a	s ys	dical	d				
X 6	ding I	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy				
Box	atten for us	lan	in the past 12 months?	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of del Month	Day Year
Vision of Vital Records, P.O. Box 68 Attending Physician: The law requires that the death certifica	ed by the attending ph detached for use as it	Completed by Physician/Med	1 Yes 2 No 4 Pregnant at time of death 9 Unknown	Cities (specify)			
G tag	igned by	y Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
Vital Records,	n sign	d b	RESPIRATORY FAILURE		1 ☐ Yes	2 □ No 3 □ Pr	obably 4 Dunknown
00 ×	should should	lete			24a. Was an	24b. Were au	topsy findings available
Be a	certificate has b	ш			autopsy performed	prior to death?	completion of cause of
tal	After this certificate his funeral director, page	a a	25. Was case referred to medical	26. Place of Deat	1 Yes 2 (Check only one)	No 1 Yes	2 No
. <	s cert	To B	examiner?  1 Yes 2 No  Hospital: 1 Propatient 2 ER/Outpat	Othor		e 6 DOther (Sner	cify)
of Phys	er this	L L	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at	28d. Describe how		,
<b>Ö</b>	ath. r: After e funer	atlo	1 ☑ Matural 5 ☐ Pending (Month, Day Year) Injur 2 ☐ Accident investigation	Work? M 1 Yes 2 No			
Division	er death. rector: A by the fu	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town, S	t and Number or Ru	ıral Route Number,
ق ق	rs aft al Di						
osoH er	within 24 hours after death.  To the Funeral Director: A completely filled in by the fu	edical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, de control on the basis of examination and/or and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occurr	and due to the caus red at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
Toth	withi To 11	M	29b. Signature and title of certifier KUMAR SUJEE	29c. License number		Date signed (Month	
	4		times M	1000		03.17.	2005
	X		30. Name and address of person who completed cause of death (Item 23a) (Type KUMAR SUJEET, GOOD SAMA		BALT	IMORE,	MD
pr.	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature				
	riegisti	-	MAR 2 5 2005 Region S. A	A STATE OF THE STA			

DHMH 17 Rev 1/2001

DOROTHY ELIZA

BROWN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No.-Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** March 2005 6.04 /Medical 4c. County of Death 4a. Fecility Heme (Knowinstitution, give street and number) 4b. City Town or Location of Death Examiner Beltimon ma shital Dinai If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6JSex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 F 5 212-60-8703 MA Director 7-1953 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Baltimore 1<del>☐Yo</del>s 2 ☐ No Completed by Funeral Director MI 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 ttan 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. other traumatic event, the Medical Examiner 1 Never Married 2 Warried Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2 ☐ No Specify: Specify: 190 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Services 1- ood manager marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be finent of Health and Mental Int. If item 27 is marked of Obje Darnes Nc Smith Strile 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 19a. Informant's Name/Relationship (Type, Print) Circle mills 252 Pittston Owings Tregory 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ö permit. Page Department o Important: if eny injury or once. 29-05 Kest Hanover IMW ' 4 ☐ Donation 5 ☐ Other (Specify) (pmeters 22. Name and Addr ss & Facility 872 & Libert (Rd Randell Stown mo 21. Signature of Fun val Service Lice 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21133 Service Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** onsessive disease or condition resulting in death) /Medical Due to (o( as a consequence of): **Examiner** pars axau myo Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequ Physician/Medical Examiner the burial-transit or Attending Physician: The law requires that the death certificate be executed er teusce Due to order a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE for use 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ∰ hknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an director, page 2 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) examine 1 Yes Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗌 No Certification: To 2 ER/Outpatient 3 □ DOA er of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 V Natural 5 Pending investigation Injury after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) determined filled in by 4 Homicide within 24 hours a

To the Funeral C

completely filled i 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0021730 an

DHMH 17 Rev 1/2001

State Registrar

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who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🔱 🗓 🖔 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March  $23^{\text{Day}}$ 2005 Year **Physician** Benno Ballnus 2:45a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5110 Old Court Road Randallstown Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1₽M 2□F Months Days Hours Min. 212-38-0281 Director 3 1931 Germany Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 27 is marked other then "naturel", or items 23e or 28e-f show treumatic event, the Mydical Examinatival by nutified at Md Baltimore Randallstown Director 1 ☐ Yes 2 1 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5110 Old Court Road 21133 USA death 1 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2√☐ No If Yes, Give A Year or Dates: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. e filed within 72 hours after cal Hygiene. I hygiene. I other then "naturel", or Iten 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) home improvement electrician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 12 should be fi and Mental H Is marked ot Max Patega Gertrude Ballnus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Importent: if Item 27 Is n any injury or other treum Lisa Ballnus (spouse) 5110 Old Court Rd., Randallstown, Md 21133 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Sykesville, Md Lake View Memorial <sup>¹</sup> 4 □Donation 5 □Other (Specify) 3-26-05 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Dage Haight Herbert P.O. Box 195 Sykesville, Md 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Deostate Cancer Physician disease or condition resulting in death) YEAR /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Listage of Figure) Due to (or as a consequence of) Examine attending physician and for use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 🗀 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Yes 2 No 3 Probably 4 Unknown leted 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2**√**□ No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA T<sub>o</sub> 28a. Date of Injury (Month, Day Year) within 24 hours after death.

To the Funerel Director; After the completely filled in by the funeral. 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D33759 2 MB 03/23/2005 36. Name and address of person who completed cause of death (Item 23a) (Type, Print) Arif Hussain, M.D. University of Maryland, Greenebaum Cancer Center 22 S. Green St, Baltimore MD 21201

State Registrar

31. Date filed (Month, Day, Year)
MAR 2 5 2005



			1 - State Registrar	tate of Man		artmen rtificate				R	g. No. 2	005	
	Physic		Decedent's Name (First, Middle, Last)     Rose	1. Ball					1	2. Date of Deat Month March	Day 23,	2005	3. Time of Death 10:16pm M
	/Medi Exami		4a. Facility Name (If not institution, give stre Continuum Care				Syk	Location of I	le			inty of Death	
	Funeral Director		5. Social Security Number 6. Sex 1 M  218-01-9555 1 M  Usual Residence of Decedent	7. Age (II	n yrs. last birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hours	Min.	B. Date of Birth (Month, Day, Aug 14.	<sup>Year)</sup> 1913		lace (State or Foreign stry) York
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other than "natural", or itams 23a or 28a-f show other traumatic event, the Medical Evant art must be redified at	To Be Completed by Funeral Director	3				kesville  10f. Zip Code  21784  Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 Yes 2 No Specify:  dent's Usual Occupation kind of work done during most of working DO NOT use retired)  Ssemblyman  18. Mother's Name (First, Middle, Alfia Tiero  ng Address (Street and Number or Rural Route Number)			ify Yes or No- can, etc.)	Specify: White  16b. Kind of Business/Industry  Westinghouse Corp.  Maiden Surmame)		
Baltimore, Ma	permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any injury or other trau		Mrs. Geraldine Connelly (Niece) 638 River Road Sykesville, MD 217.4  20a. Method of Disposition  1 Xi Burial 2 Cremation 3 Removal from State  1 Connelion 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Lorraine Park Cemetery 3/28/2005 Baltimore, MD  21. Signature of Funeral Service Licensee  22. Name and Address of Facility, HAIGHT FUNERAL HOME & CHAPEL (P.O. Box 195)  Sykesville, MD 21784 (410)-795-1400								wn, State		
8760,	isate be executed  Wedical Examiner  Whysician and the burial-transit	licai Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):								Approximate Interval Between Onset and Death		
Spring of the first of the following services of the first of the first of the following services of the first of the following services of the first of the firs						in Part I.		1 ☐ Ye 24a. Was ar autopsy	acco use co	ontribute to the	Day Year e cause of death? ably 4 Minknown by findings available		
Division of Vital F	al or Attending Physician: The laving terms after death.  I Director: After this certificate has din by the funeral director, page 2	Certification; To Be Cor	25. Was case referred to medical examiner?  1				A Other  3c. Injury: Work?	4 Nursi	ing Home	Check only one  5 Resider  d. Describe hor	nce 6 Co	Other ( <i>Specify,</i> urred	2 No )  Route Number,
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one)  2 Medical Exeminer: 29b. Signature and title of certifier	an: To the best of m On the basis of exa and manner stated	amination and/or inv	restigation,	t the time in my opi License	nion, death o	olace, and	at the time, da	te and place	manner as sta e, and due to ned (Month, E	the cause(s)
H	July 3		30. Name and address of person who comp  SHAHIDA FIDDIO3  31. Date filed (Month-Date Year)	an.	6212 5	Print)		LLE	R	OAD S	J KER	<u></u>	= ~10 21784
	Sta Registi		31. Date filed (Mark Page 15") 2005	Core Registrar's	Signature	de							

amend item#20b, perfh, G841, 3/25/05 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 19, 2005 4c. County of Death 2231 Kobert March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 8. Dete of Birth (Month, Day, Year) NIA 7. Age (Inlyrs. last birthday) Johns Kinis BAHMORE L If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 212.42.9906 150M 2 0 F Months Days Hours Min 60 Yrs. MD Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Baltimore MD 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? tvenue 21213 2862 Lake Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced "natural". 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 12th grade Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ould be f permil. Pages 1 and 2 should be Department of Health and Menta Important: If tiem 27 is marked any injury or other traumatic events. is marked 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rumb oute Number, City or Town, State, Zip Code) Barner WAY, Brother SPRUCE 10204 ELUCOT Kenneth mo 20a. Method of Disposition Date 20c. Location - City or Town, State 1 🗷 Burial 2 □ Cremation 3 □ Removal from State Hanover, MD 03.24.05 \* 4 ☐ Donation 5 ☐ Other (Specify) And association Funeral Styles MD 21229. Baltimore National Pike Balto MD 21229. 21. Signature of Funeral Service Licensee 23a. Part 1. Enter disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 4 days Fulliment Heparic Failure
Due to (or as a consequence of): /Medical Examiner 17 clays Sepsis Sequentially list conditions, Examiner as a consequence of) cause. Enter Underlying Cause (Disease or injury burial-transit The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 🛣 No 3 Ectopic pregnancy Day Month Year 4 Pregnant at time of death 5 Other (specify) signed by the a detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Immune Deficiency Syndrame should peen 24b. Were autopsy findings available prior to completion of cause of death? page 2 s has autopsy performed? certificate 1 Yes 2 No 2 No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🕱 No 1 Nnpatient 2 ER/Outpatient 3 DOA this filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27 Manner of Death 28d. Describe how injury occurred Certification: Director: After 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral [ 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 March 19, 2005 RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LEUS TL strup Resident Johns Hoyking Hospital 600 No.
31. Date filed (Month, Day, Year) 37 Registrar's Signature with Wife Street Daltimor, Muryland 21287 Registrar's Signature State MAR 2 5 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Name (First, Middle, Last) BARGER Physician March 11:34 AM 18 **200S** /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Medical ltimore If Under 24 Hrs 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) 5. Social Security Jumber Date of Birth (Month, Day, Year) **Funeral** 12 M 2□F Hours 55 Director 01/12/1950 217-54-2170 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County 28a-f show other treumatic event, the Medical Examinar must be notified at 1 Yes 2 No Director MD Baltimore City **Baltimore** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death wil nent of Heatth and Mental Hygiene. ont: If item 27 Is marked other than "neturel", or Items 23a o United States 4106 Frankford Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Tes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Higher Education College (1-4or 5+) Elementary/Secondary (0-12) Mail Services 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Agnes E. Tolson Warren O. Barger ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Importent: If item 27 Is any injury or other tree once. Patricia K. Sebeck/ 4106 Frankford Avenue Baltimore, MD 21206 20a. Method of Disposition
1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) **Balĭimore**, Date 20c. Location - City or Town, State Mar 23 \* 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland Chesapeake Crematory Inc. 2005 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation and Funeral Alternatives 11100382 Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** alcohol Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) o 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2□ No Division of Vital Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes this 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death Certification: After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funerel D 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier DS6399 who completed cause of death (Item 23a) (Type, Print)
N, MD 301 St. HAUL ST Baltinune nub 21201 Begistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 1-Certificate of Death Reg. No. 🚄 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 65 **A** M 2005 DowniForn MARGAREI /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Towsons KALTIMORE RETIREMEDI ETENOWALD HOME If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Hours 95 Months 1□M 20F 215.28.4292 . 1910 Director MARYLAND Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State or 28a-f show the Medical Examinant rust by notified at 1 Yes 2 No MD BALTIMORE Director 1000000 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number filed within 72 hours after death with 21286 150 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status I □Yes 2 ☑ If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married ŏ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: Completed by NHLIE 3 Widowed 4 □ Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) or rivgiene. Elementary/Secondary (0-12) College (1-4or 5+) (Next) 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be filment of Health and Mental Hisant: If item 27 Is marked other pe y AEGAR EILICH IA SHOL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If item 27 is any injury or other training. BODDIFORD. I IMODIUM. 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Methed of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State MARKULLE MID 22. Name and Address of Facility Evans CHAPEL OF MEMORIES DRELAND MEM. \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature a Funeral Service Licensee BALLIMORE, MD 21234 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 2400 disease or condition resulting in death) /Medical Due to (or as a consequence **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequ Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit the attending physician and Due to (or as a consequence of) Box 68760 Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav 4☐ Pregnant at time of death 5 Other (specify) P.O. I page 2 should be detached 9 Unknown à 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 2 No 3 Probably 4 Unknown 1 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 2□ No 1 Yes funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 ursing Home 5 - Residence 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 6 ☐Other (Specify) Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1 Natural 2 Accident after death. 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical completely (Check o To the 29c. License number 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifie 05

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

of de

Registrar's Signature

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State of Maryland / Department of Health and Mental Hygiene UU 5

1 - State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) BRAGINSKAYA Year Month 0750 **Physician** YEV DOKIYA MARCH 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NONTHWEST MANDALLSTOWN 3ALTIMORE SUBACUTE AT Months Days Hours Min. 8. Date of Birth Man. APR. 21, 1911 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 👿 F UKRAINE 93 219-33-3089 Director Usual Residence of Decedent 10d. Inside City Limits 10h County 10c. City, Town or Location 10a State or 28a-f show the Medical Examiner hast be notified at 1 May Yes 2 □ No BALTIMORE Completed by Funeral Director 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number USA 5900 PARK HEIGHTS AVENUE #205 21215 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a any injury or other traumatic event. It a Medies Farmandonce. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married WHITE 1 ☐ Yes 2 X No Specify: Specify 3 

Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **BIOCHEMISTRY** CHEMIST 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (UNKNOWN) BRAGINSKIY (UNKNOWN) NAUM 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 410 ROCKFLEET ROAD #203 - TIMONIUM, MD 21093 NINA NAPADOW / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE HEBREW CEM. 03/24/2005 REISTERSTOWN, MD `4 ☐Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final SCHEMIC Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examiner The law requires that the death certificate be executed physician ar s the burial-tr Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) P.O. I the 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hinknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 Yes 2 1 No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifice 25. Was case referred to medical examiner? 26. Place of Beath (Check only one) Be Other: 4 ursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 TYes 2 No 27. Many r of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide To the Hospital within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 37333 MARCH 23,2003 SALTO MO 21133 MO MAVI NHC 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 2 5 2005 Registrar

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			1 - For State Registrar	State of M	aryland / L	Department of F Certificate of I		_	giene Reg. No. 2005	5 1015		
	Physic		1. Decedent's Name (First, Middle, La. Helen Anne Burton	,		<u> </u>		2. Date of De Month	ath Day Year	3. Time of Death		
	/Medi Examii Funeral Director		4a. Facility Name (If not institution, give Good Samaritan  5. Social Security Number 6. S  214-36-7668	Hospital	ge (In yrs. last bir	Baltin	If Under 24 Hrs. Hours Min.	8. Date of Birt	th y, Year)  4c. County of Dea	2 0		
-	the Maryland 28a-f show	or	Usual Residence of Decedent  10a. State  10b. County  Maryland  Baltimor	ρ	10c. City, Tow			CLOBEL	0,1730 III	10d. Inside City Limits 1 ☐ Yes 2 X No		
	th with the Maryla 23a or 28a-f shov ust be mutilled at	I Direct	10e. Street and Number 1735 Red Oak Rd.		Darein	10f. Zip Code 21234			10g. Citizen of What C	ountry?		
036	within 72 hours after death with the Maryland ene. than "netural", or Items 23a or 28a-f show re Madical Examination at the malified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 🛣 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:		13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☒️ No	ispanic Origin? (Spe an, Mexican, Puerto f Specify:	cify Yes or No- Rican, etc.)	- 14. Race - Am Black, Whi	erican Indian,		
21215-0036	ithin 72 ho ne. nen "netur nen "netur	Completed	15. Decedent's Ec (Specify only highest gra	ucation de co <i>mpleted)</i> College (1-4or:	5+)	Decedent's Usual Occup. (Give kind of work done of life. DO NOT use retired	during most of workir f)	ng	16b. Kind of Business	s/Industry		
Maryland 21	2 should be filed within 72 hours after dea and Mental Hygiene. Is marked other than "netural", or Items eumatic event, It e Marital Examination	To Be Coi	12 17. Father's Name (First, Middle, Last) Albert Carozza			office mana	ger 18. Mother's Name Helen Coa	,	Services Maiden Surmame)			
	and 2 sho ealth and I m 27 is me		19a. Informant's Name/Relationship (Diana Burton/daug		10	Mailing Address (Street and 14 Alexandri	ia Way - E	Bel Air	, MD 21014	+		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural; or Items 23a any injury or other treumatic event, the Medical Examiner until 2008.		Oa. Method of Disposition    Burial   2XCremation   3   Removal from State   20c. Location - City or Town, S									
	Physician /Medical		23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Metas	ne.	Lung Car	g, such as cardiac of	Pat CII	rest,	Approximate Interval Between Onset and Death		
760,	e be executed sician and burial-transit	sal Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	a consequence of							
.O. Box 687	The law requires that the death certificate be the has been signed by the attending physic tage 2 should be detached for use as the b	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome	2 Fetal death	3 □Ectopic pregnancy 5 □ Other (specify) _			23d. Date of de Month	livery Day Year		
rds, P.	quires that in signed t uld be det	by	Part II. Other significant conditions of	entributing to death b	ut not resulting in	the underlying cause give	en in Part I.		bacco use contribute to	o the cause of death?		
al Records,		Completed						24a. Was a autop perfor	sy prior to	utopsy findings available completion of cause of 2 No		
n of Vital	ng Phys ter this neral dii	on: To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death 1 Natural 5 Pending	Hospital: 1 121npatie 28a. Date of Inju (Month, Daj		ime of 28c. Injury	at 2	e 5 Resid	ne ence 6 □Other (Spe ow injury occurred	cify)		
Division	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injuding, etc	ury - At home, fai c. (Specify)	M 1 ☐ \	Yes 2 □ No	8f. Location (S City or Tow	treet and Number or Ri n, State)	ural Route Number,		
	he Hospiti in 24 hours he Funera pletely fille	Medical C	29a. Certifier 1 ☐ Certifying Phyone) 1 ☐ Medical Example 2 ☐ Med	rsician: To the best iner: On the basis of and manner sta	examination and	death occurred at the tim For investigation, in my op	e, date and place, ar pinion, death occurre	nd due to the c	cause(s) and manner as date and place, and due	s stated. to the cause(s)		
	Tot Comp	Z	29b. Signature and title of certifier  Current Vac	fatur	>	29c. License			29d. Date signed (Mont.)			
	10		30. Name and address of person who charles Padgett	MD 560	Loch	Type, Print) Raven Bou	levard, B	Baltim	ore, MD 2	1239		
	Sta Registr		MAR 2 5 2			Society.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death Reg. No. 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) March **Physician** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** a Year If I Inder If Under 24 Hrs. 8. Date of Birth (Month, Day last birthday) (State or Foreign 5. Social Security Number 6. Sex **Funeral** Months Days Hours M 2□F Director Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 28a-f shov other treumstic event, the Medical Exacular must be notified at Yes 2 □ No MORE Director 10g. Citizen of What Country and Number 10f. Zip Code ŏ 238 Completed by Funeral 2 should be filed within 72 hours after death v and Mental Hygiene. Is marked other than "naturat", or Items 23: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 100 1 ☐ Yes 2 ☑ No Maryland 21215-0036 Specify: Year or Dates: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 1 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be RGAN ပ 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Pages 1 and 2 s ment of Heelth an Department of Heelth a Importent: If item 27 is any injury or other tree 90059. 6800 WEERTY 20b. Place of Disposition (Name of Ametery, crematory or other p Baltimore, 20a. Method of Disposition Date Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 □Removal from State Ematin \* 4 ☐ Depation 5 ☐ Other (Specify) 22. Name and Address of Cility 1.01 Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ard Imyd Datky /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner to the Hospitel or Attending Physicien: The law requires that the death certificate be executed for use as the burial-transit Due to (or as a consequence of): Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 5 ☐ Other (specify) P.0. the detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ funeral director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 🗆 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Yes hospice this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Natural 1 Tyes 2 🗌 No within 24 hours after death. To the Funerel Director: A 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical completely 29d. Date signed (Month. Day, Year) 29c. License number •} ne and address of person who completed cause of death (Item 23a) (Type, Print) 301

State

Registrar

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gistrar's Signature

-2003			uendle lik. Elisule Ali	-	gible.
	1 - For State Registrar		artment of Health and Me ctificate of Death	Reg. No. 2	005 10157
	1. Decedent's Name (First, Middle, Last)			2. Date of Death	3. Time of Death
Physiciai /Medica	111111111111111111111111111111111111111	per		Month Day MARCH 19, 2	2005 1651 P <sup>M</sup>
Examine	4 101 105 11 1	et and number)	4b. City, Town, or Location of Death		nty of Death
	5706 RADECKE AVENUE	3	BALTIMORE CITY		N/A
Funeral	5. Social Security Number 6. Sex	7. Age (In yrs. last birthday) 2□ F	If Under 1 Year If Under 24 Hrs. § Months Days Hours Min.	B. Date of Birth (Month, Day, Year)	Birthplace (State or Foreign Country)
Director	216-52-9924 152 M	55 Yrs.	M	lar. 2,1950	Maryland
rland ow	10a. State 10b. County	10c. City, Town or Lo	cation		10d. Inside City Limits
Man,	Maryland N/A	R=	ltimore		X☐Yes 2☐No
or 28s	Maryland N/A  10e. Street and Number		10f. Zip Code	10g. Citizen	of What Country?
U36  ours after death with the Marylan fel; or Items 23a or 28a-f show Examining ITMS Let Trivillied at	5706 Radecke Ave	Apt.c3	21206	IIC	7\
tems	11. Marital Status	Was Decedent Ever in U.S. Armed Forces?	Vas Decedent of Hispanic Origin? (Spec f Yes, specify Cuban, Mexican, Puerto R	ify Yes or No- ican, etc.)	A lace - American Indian, Black, White, etc.
36 rs after	1 Never Married 2 Married 3 Widowed XXDivorced	1 Tyes & No	☐ Yes 2½ No Specify:	Spe	
1215-0036 within 72 hours after death with the Maryland one. then "natural; or Items 23a or 28a-f show the Madical Example of Truest be rediffed at	15. Decedent's Educati		lent's Usual Occupation	16h Kind o	Business/Industry
215 hin 72 nn na	(Specify only highest grade co	College (1-4or 5+)  (Give life. L	lent's Usual Occupation kind of work done during most of working OO NOT use retired)		
d 212 filed with Hygiene. wher the	15. Decedent's Educati (Specify only highest grade of Elementary/Secondary (0-12)  12th grade  17. Father's Name (First, Middle, Last)		k Driver	Unite	d Products
nd be file doth	17. Father's Name (First, Middle, Last)			First, Middle, Maiden Sum	ame)
Iryland 21215-0 should be filed within 72 ho Id Mental Hygiene, marked other then "natur matic event, the Medical	e Gilbert Coo		Elnora		
<u>a</u> = a : a	19a. Informant's Name/Relationship (Type,		g Address (Street and Number or Rural I		
1 9 a a a a	Lacretia A. Coope				n - City or Town, State
ages ages of the first of the f	1 🔀 Burial 2 ☐ Cremation 3 ☐ Rem	oval from State  Cemetery, crem  King Mom	orial Park 3/26		awn, Maryland
Baltimore, permit. Pages 1 ar Department of Heam poortant: If Item my injury or other these.	* 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Ligensee		OTIGI FALK	1	
Baltimore permit. Pages 1 Department of H Important: If iter any injury or ott	Veras terre	52	Name and Address of Facility Chat 40 Reisterstown	cman-Harrı; Rd Baltim	S Funeral Home
	23a. Party. Enter the disease, or complicat shock, or heart failure. List only one of	ions that caused the death. Do not ente	er the mode of dying, such as cardiac or	respiratory arrest,	Approximate Interval Between
Physician	Jamediate Cause (Final		OSCLEROTIC CARDIOV	ASCIII.AR DISE	Onset and Death
/Medical Examiner	resulting in death)	Due to (or as a consequence of):	occupation of the form	INCOMM DICE	
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W B E	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):			
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death certifica	IF FEMALE: 23c. 23c.	If yes, outcome of pregnancy 1□Live birth 2□Fetal death 3□	Ectopic pregnancy		Date of delivery
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ords, P.O. Borrequires that the death een signed by the attentiould be detached for the high by Physician	9 Unknown			00 Bitti	
<u>8</u> 8 9 7		uting to death but not resulting in the un	derrying cause given in Part I.	1 Yes 2 No	ontribute to the cause of death?  3 Probably 4 Unknown
e la e la la se 2 de 2 de 2 de 2 de 2 de 2 de 2 de 2		f		24a. Was an 24t autopsy performed?	. Were autopsy findings available prior to completion of cause of death?
Vital Finition: The certificate rector, pag			00 81	1 Yes 2 <sup>th</sup> No	1 ☐ Yes 2 ☐ No
- × v = .c	a examiner?	pital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	26. Place of Death (company)		ther (Specify) SCENE
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Ditel control of the					
Divisio  To the Hospitel or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the tu	29a. Certifier 1 Certifying Physicia (Check on 2) 2 Medical Examiner:	On the basis of examination and/or invi	occurred at the time, date and place, and estigation, in my opinion, death occurred	d due to the cause(s) and r at the time, date and place	manner as stated. e, and due to the cause(s)
o the o the o the o mple	29b. Signature and title of certifier	and manner stated.	29c. License number	29d. Date sign	ned (Month, Day, Year)
F 5 F 0	V/ a. lol	amo	OCME	MARCH	20, 2005
20	30. Name and address of person who compl	leted cause of death (Item 23a) (Type, F	Print)	1	
	30. Name and address of person who compl T. What Welke		1 Penn Street Bal	timore, Mary	land 21201
State	31. Date filed (Month, Day, Year)	32. Eegistrar's Signature	adio		
Registrar	MAR 2 5 200	5 States to Ap	7 - 2		

State of Maryland / Department of Health and Mental Hygiene 2 0 0 5 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death March 19, Day 2005 **Physician** Robert Louis Diserens 8:50 A.M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Harmony Hall Assisted Living Columbia Howard If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Sept. 26, 1920 Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1X M 2□F Director 350-16-6620 84 Yrs Lowa Usual Residence of Decedent the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show other treumatic event, the Medical Examiner must be notified at 1 d Yes 2 □ No Directo MD Columbia Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6336 Cedar Lane #220 "natural", or Items 23a 21044 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ X/es 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry 12 should be filed within 72 h and Mental Hygiene. 7 Is marked other than "ni (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4+ Civil Engineer Ceco Steel Corp 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Albert J. Diserens Ruth Knickerbocker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Importent: If item 27 Is n any injury or other treun Ann Dahlin / Daughter 4505 Mt. Olney Lane, Olney, Maryland 20832 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Chesapeake Crematory 3/24/05 <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) Beltsville. 22. Name and Address of Facility Fleck Funeral Home, Inc. 21. Signature of Funeral Service Licensee m00869 7601 Sandy Spring Road, Laurel, Maryland 20707 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or beart failure. List only one cause on each line. 23a. Part1. En Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) 4 days /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) certificate be executed the burial-transit Causa (Disease or I that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Box 68760 Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9□ Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Qunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performe certificate 1 Yes 2 X No To the Hospitel or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide within 24 hours a To the Funeral E 29a. Certifier Medical To Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item, 23a) (Type, Print) 31. Date filed (Month, Day, Year)

State Registrar

MAR 2 5

2005

		•	For State Registrar	State of Ma	arylan		rtment tificate			and M		giene Reg. No. 🤈	005	10150
Dhy	/sicia		1. Decedent's Name (First, Middle, La								2. Date of De Month MARCH	ath Day	Year	3. Time of Death 3
	/sicia ledic	al	Norman Charl				dh Oh T		1	-( Danah	MAKCH		2005	8:30 A M
Exa	amine	er	4a. Facility Name (If not institution, giv		_		4b. City, T BALT			of Death		1	unty of Death	
F			5. Social Security Number 6. S			last birthday)	If Under	1 Year	If Under	24 Hrs.	8. Date of Bir			lace (State or Foreign
Fund Direct				<b>X</b> M 2□F	69	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da June 6,	1935	Mari	elace (State or Foreign htry) Iland
ъ			Usual Residence of Decedent		10- 0	. Taua I -								0d, Inside City Limits
arylar show	1	_	10a. State 10b. County		TOC. CIL	y, Town or Lo							'	1 ☑ Yes 2 ☐ No
he M	offile	ecto	Maryland N/A  10e. Street and Number			80	utimo				Т	10g Citizen	of What Cour	
with the or	3	ă	3505 Glenmore	Анопио			TOI. Z.p		206			-	S.A.	,
deeth	3	Funeral Directo	11. Marital Status	12. Was Decedent	Ever in U	.S. 13. \	Was Decede			gin? (Spe	cify Yes or No Rican, etc.)		Race - Americ	
after o	ag	Fu	1 ☐ Never Married 2 🂢 Married	Armed Forces? 1 XYes 2 □ If Yes, Give	No	ì	t Yes, speci 1 ☐ Yes 2		n, Mexican Specify:		Hican, etc.)		Black, White,	orc. hite
ours a	Exa	l by	3 Widowed 4 Divorced	Year or Dates:			11165 2	LX INO	эрөспу.					
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within than	W S	dui	Elementary/Secondary (0-12)	College (1-4or 5	5+)					Supe	rvisor			is unu
IIIU Z I Z I 3-UU30 be filed within 72 hours after deeth with the Maryland nal Hygiene. nd other than "natural", or Items 23e or 28e-f show	aut,	e C	17. Father's Name (First, Middle, Last			0000					(First, Middle			
Itan Itabe Tental	lic ev	To B	Charles D	rimal					Ма	vry	A. 1	Гита		
EXILITIOFE, MIXIVIATIO 2.12.13-0030 permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23e or 28a-1 show	Irauma		19a. Informant's Name/Relationship Mrs. M. Audrey D	,, ,	601		-	•			l Route Numb Ltimore			Code)
1 and Health	ther	-	20a. Method of Disposition	tunac (voc		Place of Dispo					ate		ion - City or To	own, State
ages int of t: If it	y or o		1 X Burial 2 ☐ Cremation 3 [	Removal from State		rkwood				3/26/	2005	Balti.	толе. Т	Maryland
Dallimore, Demit. Pages 1 a Department of Hea mportant: If item	injur e		*4 Donation 5 Other (Speci 21. Signature of Fuheral Service Lice		1 00						imunek			
Deg E	ono		* (WIND			9:	705 Be	rlai	r Rd.	, Ba	ltimor	2, MD	21236	
Physic	ian		23a. Part1. Errer the disease, or con shock, or heart failure. List only Immediate Gause (Final disease or condition	plications that caused one cause on each li	ne.			-			r respiratory a	rrest,		Approximate Interval Between Onset and Death
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s/ou, ate be executed nysician and	ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c										
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<b>55/7</b> ifficate b g physic	the b	dicai	•	d										
RECORGS, P.O. BOX 68/ The law requires that the death certificate tile has been signed by the attending phys	or use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 Feta	aldeath 3□	Ectopic pre					23d	. Date of delive Month	ery Day Year
the d	ched	ysic	1 Yes 2 No 9 Unknown	9□ Unknown										
dS, Puires that signed b	be	by	Part II. Other significant conditions PARAPLEGIA SEG							_	23e. Did t	_/		ne cause of death?
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HeC he faw e has	page 2	dmo	Victorial (1-7-0)	110   20 (10.								ormed?	death?	mpletion of cause of 2 No
		e C	25. Was case referred to medical						26. Place	of Death	1 ☐ Yes	2 02 No one)		20110
ysicia ysicia	director,	OB	examiner? 1 Yes 2 No	Hospital: 1 Inpatie	ent 2	] ER/Outpatier	nt 3□ DO	A Othe	9r: 4 ☐ Nu	ırsing Ho	me 5□Resi	dence 6	Other (Specif	y)
ON OT ding Phy h. After this	funeral	Certification: T	27. Manner of Death  1 Natural 5 Pending investigation	28a. Date of Inju (Month, Da	y Year)	28b. Time of Injury	M 28	8c. Injury Work	rat c? Yes 2□		28d. Describe	how injury o	ccurred	
DINISION I or Attending after death. Director: Afte	by the	fical	3 Suicide 6 Could not l	28e. Place of Ini	ury - At h	ome, farm, str							umber or Rura	al Route Number,
after Dire	.⊆	erti	4 Homicide	building, et	c. (Speci	fy)					City or To	wn, State)		
DINISION OF VITA Hospitel or Attending Physician: 24 hours after death. Funeral Director: After this certific	etely fille	edical C		hysicien: To the best miner: On the basis o and manner st	f examina									
To the Hosp within 24 ho To the Fune	удшог	Me	20h Cigneture and title of contifier		)		29c.	. License	number			29d. Date s	igned (Month,	Day, Year)
- 5 -	0		Immy /	MMM	/		D	151	35			MARC	H 23,	2005
10210	1		30. Name and address of person who	completed cause of o	death (Iter	m 23a) (Type,	Print) HEN	BLV	D. ,BA	ALTIA	AORE,			
Re	Sta egistr		31. Date filed (Month, Day, Year)  MAR 2 5			ature			1	· · · · · · · · · · · · · · · · · · ·				

NORMAN CHARLES DRIMAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) March 23 **Physician** Anita Mildred Dyson 2005 1:53p /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Carroll Westminster Carroll Hospital Center 5. Social Security Number 012-16-6501 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months 1 ☐ M 2 🕅 F 83 Yrs. Massachusetts Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Exam, ar must be notified at 1 ☐ Yes 2 No Md Carrol1 Eldersburg Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6313 Georgetown Blvd. Apt D 21784 USA Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1⊕]Yes 2□No IKYes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married WWII 1 ☐ Yes 2√∑ No Specify: Specify white 3√ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) s and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) homemaker domestic 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental sht: If item 27 is marked o Charles Harris Marcellina Rego 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2007 Advisory Ct., Eldersburg, MD 21784 Sharon Allia (daughter) other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Bunal 2 Cremation 3 Removal from State ö permit. Page Department of Importent: If any Injury or once. All County Cremation 3-24-05 Sykesville, Md ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel ▶ Pruge Haight D erbert P.O. Box 195 Sykesville, Md 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ischemic BOWL **Physician** 244000 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day ò in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) the i detached 9 Unknown þ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Renti 141UR4 C ITTOOK 1 Yes 2 No 3 Probably 4 Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Division of Vital Records, P.O. Box 68760. certificate has or Attending Physician: funeral director, this After t efter death. n 24 hours efter der he Funerel Directo nletely filled in by th

Hospitel

Baltimore, Maryland 21215-0036

Certification: To

2 No 1 Yes Manper of Death

1 Natural

4 Homicide

29a. Certifier

Medical

State

completely

within 2 To the To the

5 Pending investigation 2 Accident 3 🗀 Suicide

6 Could not be

1 Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) 28b. Time of

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

(Check only one) and manner stated 29b. Signature and title of certifier

29c. License number 031660 29d. Date signed (Month, Day, Year) 03/24/2005

WESTMWETER

MALY LANG

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2005

711 HOWAS GALVIN 31. Date filed (Month

32. Registrar's Signature

STONER AVENUE 291

			1 - For State Registrar	State of I	Maryland / Depa Cea	artment of Hertificate of E	ealth and Death		iene2 0 0 5	10161	
	Physic /Medi		1. Decedent's Name (First, Middle, Mary Ewalda					2. Date of Death	23°°2005°°°	3. Time of Death 6:40a <sub>M</sub>	
	Exami		4a. Facility Name (If not institution, MARIA HEALTH CA 5. Social Security Number	RE CENTER	er) Age (In yrs. last birthday)	4b. City, Town, or Baltir			4c. County of Death Baltim	ore .	
	Funeral Director		213-78-7916 Usual Residence of Decedent	1□ M 21 F	90 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birth Cou	place (State or Foreign ntry) CI'Many	
	with the Maryland a or 28a-f ehow Lea notified at	ector	MD Baltim  10e. Street and Number	ore	Baltimo					10d. Inside City Limits 1 ☐ Yes 2X No	
	death with	Funeral Director		es St.	nt Ever in U.S. 13.1	21212 Was Decedent of His f Yes, specify Cuban	panic Origin? (S		Og. Citizen of What Cou USA		
9000	hours after urel', or ite	Ď	Mever Married 2☐ Marrie 3☐ Widowed 4☐ Divorced	Armed Force d 1 □ Yes If Yes, Give Year or Date	No.	fYes, specify Cuban 1 ☐ Yes 2 ☐ No	Specify:	o Rican, etc.)	Black, White,		
21215-0036	2 should be filed within 72 hours after death with the Maryla and Mental Hygiene. Is marked other than "nature!", or Iteme 23a or 28a-f ehov aumatic event, the Medical Examinar must be notified at	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-40	(Give	dent's Usual Occupat kind of work done du DO NOT use retired)	ion iring most of wo	rking	6b. Kind of Business/In	ŕ	
Maryland ?	ould be filed Mental Hyg arked othe atic event,	To Be C	17. Father's Name (First, Middle, La Joseph Daimer	•			Kathar.	ne <i>(First, Middl</i> e, M ina Kair	aiden Sumame) 1d1		
	무를당한	1	19a. Informant's Name/Relationship Bernice Feilin 20a. Method of Disposition		D 6401	N. Char	les St	. Balto.	City or Town, State, Zip , MD 21212 0c. Location - City or To	2	
Baltimore,			1 ☐ Burial 2 ☐ Cremation 3  1 ☐ Donation 5 ☐ Other (Special Service Li	ocify)	Villa Ma	_	3/2		elen Arm,		
B	Dep imp		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
1	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	neuman	a			-	Interval Between Onset and Death	
	Examiner	nlner	Sequentially list conditions, if any, leading to animodate cause. Enter Underlying Cause (Disease or injury	b. Oue to (or s	as a consequence of):	cerebral	urfar	etan"		24 mointis	
8760,	icate be executed physician and s the burial-transit	dical Examiner	that initiated events resulting in death) Last	c. Due to (or a	s a consequence of):						
P.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ory Day Year	
	w requires that been signed t should be deta	þ	Part II. Other significant condition	s contributing to death	but not resulting in the un	derlying cause given	in Part I.		23e. Did tobacco use contribute to the cause of death 1 ☐ Yes 孝□和o 3 ☐ Probably 4 ☐ Unkn		
al Records,		Completed						24a. Was an autopsy performe 1 □ Yes 2X	prior to cor death?	osy findings available inpletion of cause of	
of Vital	Physician: r this certific ral director,	To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death	Hospital: 1 ☐ Inpa 28a. Date of In	tient 2 ER/Outpatient	0.0	<b>4</b> □Nursing H	th (Check only one) ome 5 Residen 28d. Describe how	ce 6 □Other (Specify	)	
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_	Hospita 14 hours Funeral tely filled	edlcal Co	29a. Certifier (Check only one)  YCertifying 2 Medical Ex	Physician: To the bes aminer: On the basis and manners	it of my knowledge, death of examination and/or inv stated.	occurred at the time estigation, in my opin	date and place, ion, death occur	and due to the cau red at the time, date	se(s) and manner as sta e and place, and due to	ated. the cause(s)	
	To the within 2 To the comple	W	29b. Signature and title of certifier		med	29c. License r			Date signed (Month, 1) NEX (4 23		
	J		30. Name and address of person where Francis X. Ca	rmody, MD	7505 Osle		, Tows	on, MD 2	1204		
	Sta Registr	te ar	31. Date filed (Month, Day, Year) MAR 2 5 2	2005 Regis	trar's Signature	all of					

Patient known as Otella Edwards

			Please T		Indelible Ink. Ensure		_
			1 - For State Registrar		epartment of Health and Certificate of Death		giene Rog. N2 005 10162
			Decedent's Name (First, Middle, Last)		Johnnoale of Death	2. Date of De	eath 3. Time of Death
ı	Physic /Medi		Otelia D. Ed	wards		March	Day Year 8:32 P
	Exami		4a. Facility Name (If not institution, give		4b. City, Town, or Location of De	ath	4c. County of Death
- 19	- Europe I		5. Social Security Number 6. Sec	7. Age (In yrs. last birth	U III		N/A
	Funeral Director	П		M 200 77 Y	Months Dave House Mi		th y. Year)  9. Birthplace (State or Foreign Country)
	and *		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	or Location		
	Maryli f sho	tor	MD N/A		timore		10d. Inside City Limit
	th the or 28e	Director	10e. Street and Number		10f. Zip Code		10g. Citizen of What Country?
	72 hours after death with the Maryland naturel', or items 23a or 28e-1 show Jical Exartiner must be notified at		3601 ClarksLand		21215		USA
_	items items	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue	(Specify Yes or No arto Rican, etc.)	14. Race - American Indian, Black, White, etc.
21215-0036	eli, or	by	3 AWidowed 4 Divorced	tf Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No Specify:		Specify: Black
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Maryland	2 sho and I is ma		19a. Informant's Name/Relationship (Ty	0 0	Mailing Address (Street and Number or F		A 10 0
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Baltimore,	Pages nent of I snt: If it		1 ဩBurial 2 ☐ Cremation 3 ☐ R  4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	crematory or other place)	. 18 · 05	Towson, MD
alt	permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Service License				
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			23a. Part1. Enter the disease, or complishock, or heat failure. List only on	cations that caused the death. Do no	t enter the mode of dying, such as cardia	ac or respiratory ar	rest, Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Right Hip	Fracture		4 Weeks
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X Q	ath ce ttendir or use	ian/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death	3 □Ectopic pregnancy		
	0 0 0	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of death 9□ Unknown	5 Other (specify)		Month Day Year
ν, T	Attending Physicien: The law requires that the deatt ecrosath.  ecrosath.  ecrosath.  ether this certificate has been signed by the atter the function, page 2 should be detached for by the functal director, page 2.	y Ph	Part II. Other significant conditions con	tributing to death but not resulting in the	ne underlying cause given in Part I.	23e. Did to	bbacco use contribute to the cause of death?
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		Medical	(Check only 2 Medical Exemin	er: On the basis of examination and/o	or investigation, in my opinion, death occ	urred at the time, o	date and place, and due to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier		29c. License number	2	29d. Date signed (Month, Day, Year)
	di		Patrice Ma	m, MD	Kes-000		March 13,2005
1	)		30. Name and address of person who cor		nai Hospital c	of Balt	- more
	Sta	te	31. Date filed (Month, Day, Year) MAR 2 5 2005	32. Registrar's Signature	2		
	Registr	ar	11111 W 0 COOD 3	CHAIN SS JEGETHE			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar AMEND ITEM#4a&b PER PHY C841C9/11/15/11005 Daath Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** March 2005 ucie /Medical 4b. City, Town, or Location of Death institution, give street and number) 4c. County of Death **Examiner** ALTI MORE If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 KF Months Hours Min Yrs. Director 6erm the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State 28a-f shov treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director meltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with inent of Health and Mental Hygiene. 5 21208 Items 23e  $0 c \infty k$ Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 2 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced White "naturel". 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Bernharo Willie MOX ဂ္ 100 Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 nc 20a. Method of Disposition

1 Burial 2 Coremation 3 R

4 Donation 5 Other (Specify) 20b. Place of Dispositi cemetery, cremat 20c. Location - City or Town, State Department of Important: If its any injury or o 3 Removal from State -22.-05 Forest Hill Evans funeral CENTER 2325 YORK KD TIM. MD AUTERNATIVES FUNERAL-CREMATIO 23a. Part . Enter the disease, or shock, or heart failure. List Approximate 09 Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final piration Discomance **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Examiner To the Hospitel or Attending Physician: The law requires that the death certificate be executed Cause (Disease or kiljur that initiated events resulting in death) Last P.O. Box 68760. Physician/Medical the t IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, à director, page 2 should be 2 No 3 Probably 4 □Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy Yes 25. Was case referred to medicar examiner? 26. Place of Death (Check only one Hospital: Other: 1 Yes 1 Inpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of D 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 No after death death filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) : 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier completely and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number HO06/3/2 05 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BRANCH KD GLEN BURNIE MD 21060

Registrar DHMH 17 Rev 1/200

State

31. Date filed (Month, Day, Year)

MAR 2 5 2005

FURMACE

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	-	1- State of Maryland /		rtment of He tificate of D			ene () (	05	10164
Dhysisis		1. Decedent's Name (First, Middle, Last)			-	2. Date of Death	/ Day	Year	3. Time of Death
Physicia /Medica		MARGARET MARY ERWIN				MARCI		2005	1214PM
Examine	er	4a. Facility Name (If not institution, give street and number)  Stollo Movie Hooring Movey Modical Contact		4b. City, Town, or I			4c. County		
Funeral		Stella Maris Hospice; Mercy Medical Center  5. Social Security Number 6. Sex 7. Age (In yrs. last b.	irthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	· · · · · ·	9. Birthpl	ace (State or Foreign
Director		218-40-0616	Yrs.	Months Days	Hours Min.	(Month, Day, July 8,	1903	Virgi	nia
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Aaryla F sho	ŏ	Maryland n/a Balt							1√Yes 2 No
the N	rect	10e. Street and Number	THOL	10f. Zip Code		10	g. Citizen of	What Count	
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s 1 an f Heal item 3		20a. Method of Disposition 20b. Place	of Disnos	sition (Name of latory or other place		The second second second	Oc. Location		
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parmit. Pages 1 and 2 Department of Health s Importent: if item 27 is any injury or other tre		21. Signatury of Funeral Service Licenses	22.	Name and Address Mitchell	s of Facility -Wiedefel	d F.H. 1	nc.		
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BOX OR Bath certifics attending ph for use as t	N/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		5			23d. Da	ate of delive	ry
w requires that the death certific been signed by the attending p should be detached for use as	Physiclan/Medi	in the past 12 months?  1 Yes 2 No 9 Unknown		Ectopic pregnancy Other (specify)			M	onth	Day Year
d by the	Phy	9 Unknown	in the co	darking agus giva	o in Dont I	22a Did tob	2000 USO 005	stribute to th	e cause of death?
requires the	by	Part II. Other significant conditions contributing to death but not resulting	in the un	derlying cause give	nin Panti.		s 2 No	3 Proba	
v requ	letec	/6 12 12 12 12 12 12 12 12 12 12 12 12 12				24a. Was ar	24h	Were autor	osy findings available
ne lav he lav e has	Completed					autopsy perform	ed2	prior to con death?	apletion of cause of
ding Physicien: The lav h. After this certificate has funeral director, page 2	0	25. Was case referred to medical			26. Place of Death		No No	T Tes	2E NO
nysici nis cer direc	To B	examiner? 1   Yes 2   No   Hospital: 1   Inpatient 2   ER/C	Outpatient	3 □ DOA Othe	1. 4 Nursing Ho	me 5 🗆 Reside	nce 6 🗷 Ot	her (Specify	hespice
ding Phys		27. Manner of Death 1 ☑Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b.	. Time of Injury	28c. Injury Work	?	28d. Describe ho	w injury occu	rred	
Attending or death.  ector: Afte by the fune	icati	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home,	farm etro		'es 2□No	28f. Location (Str	eet and Num	her or Rural	Route Number
after Direct din by	Certification:	4 Homicide determined building, etc. (Specify)	iaini, stie	sot, raciory, onice		City or Town		00/0/7/0/6	riode ridinoor,
To the Hospitel or Attending Physicien: The law requires that the death certificate be axacuted within 24 hours attending Physicien: The law requires that the death certificate be axacuted within 24 hours attended. The the Tuneral Director: Attent his certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier 1 Certifying Physician: To the best of my knowled							
the H nin 24 the Fi nplete	Medical	one) and manner stated.	and/or my						
P M P P	~=	29b. Signature and title of certifier		29c. License	- C - I	29	2 Date signi	ed (Month, L	oay, rear/ →
	)	30. Name and address of person who completed cause of death (Item 23a	) (Tuno	DOO T	11434		1/4	10)	
W		Penasolodis Leda Kis 301	5 -	T Poul	PI Br	Himore	ind	. 21	C 6 S
Sta		31. Date filed (Month, Day, Year) MAR 2 5 2005  32. Registrar's Signature	-	1 401		1011			
Registr	ar	1111 6 3 2803 Blooms B	Coo	Les .					

			1- State of Maryland / Department	artment of Health and Mertificate of Death		ne No2005 10165		
ı	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death	Day: 3. Time of Death 3: 35A M		
	/Medic		Dolores P. Fisher					
	Examin	er 	4a. Fagility Name (If not institution pive street and number) Center	4b. City, Town, or Location of Death	n	4c. County of Death Ealtimore		
	Funeral Director		5. Social Security Number 6. Sex 7. Age ( <i>In yrs. last birthday</i> ) 1 M 2 X F 84 Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	B. Date of Birth (Month, Day, Ye Dec. 15.	9. Birthplace (State or Foreign Country) 1920 Maryland		
	D D		Usual Residence of Decedent		7ec. 15,			
	Maryla f shov	lor	10a. State 10b. County 10c. City, Town or Lo  Maryland Baltimore	Baltimore		10d. Inside City Limits 1 ☐ Yes 2 ☑ No		
	n the rr 28a-	irect	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?		
	23a c	ralD	9400 Dawnvale Road	21236		U.S.A.		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23e or 28a-f show eny injury or other traumatic event, the Medical Examinal must be notified at ones.	by Funeral Directo	1 Never Married 2 Married 1 Yes 2 No	Was Decedent of Hispanic Origin? (Spec f Yes, specify Cuban, Mexican, Puerto R 1 ☐ Yes 2 X No Specify:	ify Yes or No- ican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White		
2-0	72 hou	eted	15. Decedent's Education 16a. Deced (Specify only highest grade completed) (Give	dent's Usual Occupation	161	b. Kind of Business/Industry		
21215-0036	within iene. than	Completed	Elementary/Secondary (0-12)   College (1-4or 5+)	kind of work done during most of working DO NOT use retired) NEMARCL		Own Home		
b	al Hyg J other	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name (	First, Middle, Mai			
yla	should bent marked umatic	_C	Anthony S. Parr  19a. Informant's Name/Relationship (Type, Print)  19b. Mailin	Clara E				
Baltimore, Maryland	and 2 state and 2 state and 2 ts received to a state and a state and a state a			ig Address (Street and Number or Rural ) Dawnvale Road, Bo				
ore,	es 1 a of Hez f Item r othe		The second secon	sition (Name of Da natory or other place)		c. Location - City or Town, State		
Ē	t. Pages rtment of i rtant: If Ite		`4 □Donation 5 □Other (Specify) Dulaney	Valley Mem'l 3/26/				
Ba	permit. Departr Imports eny inji		Stefanie Rineker 9:	Name and Address of Facility School 105 Belair Rd., Bal	timore,			
k			23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.  Immediate Cause (Final MFTASTATT BRF.		respiratory arrest,	Approximate Interval Between Onset and Death		
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)  METASTATIC BREI  Due to (or as a consequence of):	HOI CHIYCER				
ď	Examiner	_	Sequentially list conditions, b.					
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Uncertying Cause (Disease or injury					
oʻ	cate be executed bhysician and the burial-transit	Exa	that initiated events c.  The sulting in death) Last Due to (or as a consequence of):					
8760,	icate be physici s the bu	edical	d					
Box 6	eath certific attending p for use as	ın/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □	Ectopic pregnancy		23d. Date of delivery		
P.O. B	that the deat led by the att detached for	Physician/M		Other (specify)		Month Day Year		
	ires that t signed by d be detad	by Ph	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.	23e. Did tobaco	co use contribute to the cause of death?		
ord	w require been sig should b				1 🗆 Yes	2 No 3 ☐ Probably 4 ☐ Unknown		
Rec	2 2 2	Completed			24a. Was an autopsy performed			
a		Be C	25. Was case referred to medical examiner?	26. Place of Death (	1 ☐ Yes 2 Check only one)	No 1 ☐ Yes 24 No		
of <	Physic this ce al dire	2	1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ☐ ER/Outpatient					
0	Attending Physicien: r death. ector: After this certific by the funeral director,	tion	27. Manner of Death  1 Natural 5 Pending (Month, Day Year)  Accident investigation	28c. Injury at 28 Work? M 1 ☐ Yes 2 ☐ No	d. Describe how in	njury occurred		
Division of Vital Records,	p aging ∈	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)	eet, factory, office	f. Location (Street City or Town, St	and Number or Rural Route Number, ate)		
	To the Hospital within 24 hours 8 To the Funeral I completely filled		29a Certifier 12 Certifying Physicien: To the best of my knowledge, death	occurred at the time, date and place, an	d due to the cause	e(s) and manner as stated.		
	the Ho iin 24 / the Fu pletely	ledical	(Check only one) Medical Exeminer: On the basis of examination and/or invane) and manner stated.	estigation, in my opinion, death occurred	at the time, date	and place, and due to the cause(s)		
	To the To the comple	Σ	29b. Signature and title of certifier	29c. License number D 37254	29d.	Date signed (Month, Day, Year)		
  -	-6		30. Name and address of person who completed cause of death (Item 23a) (Type, It			/ ( - ) (		
0			BOON P.LIM M.D. 7601 OSLER DRI	VE TOWSON MARYLA	ND 212	214		
	Sta Registr	46.7	31. Date filed (Month, Day, Year) WAR 2, 5, 2005	ule .				

			. For	State of Maryland / Dep			lental Hygie	ene	05	10166
		_1	- State RegistraAMEND ITEM #2	20b PER FH G841 399	ersifice tempf	Death	Reg	g. No.		3. Time of Death
	Physicia		1. Decedent's Name (First, Middle, Last)	TERRINE	3. 7		Month	Day	Yeer	460 PM
3	/Medic		4a. Fecility Name (If not institution, give s	FERGUSC		r Location of Death	3 1	4c. County		
	Examin	er	1777 S. MARL	YN AVE.	ESSE	X		BALT	TIMORE	5
	Funeral		5. Social Security Number 6. Sex		y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	Yeer)	Country	
	Director	-	227.84.6600 Usuat Residence of Decedent	M 2101 53 Yrs.			7.4.	452	EN	JESSE .
	yland Now	-	10a. State 10b. County	10c. City, Town or	Location				10d	1. Inside City Limits
	B Mar	ctor	MD BAUTI	MORE 1-55	EX					1 Yes 2 No
	or 28	Dire	10e. Street and Number	YN AVE.	10f. Zip Code		100	g. Citizen of W	/hat Country	/?
	eath v	Funeral Director	10 100	12. Was Decedent Ever in U.S. 13	3. Was Decedent of H	lispanic Origin? (Sp	ecify Yes or No-		e - American	
(O	after d	Fun	1 Never Married 2 Married	Armed Forces?	tf Yes, specify Cuba 1 ☐ Yes 2 ☐ No	an, Mexican, Puerto Specify:	Rican, etc.)	Specify.	k, White, etc	). 
5-0036	72 hours after death with the Maryland naturel; or Items 23a or 28a-f show disal Enaisi ast must be notified at	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			1.0		NO	MIE
	"nati	lete	15. Decedent's Edu (Specify only highest grade	e completed) (Gin	cedent's Usual Occup ve kind of work done i. DO NOT use retired	during most of work		6b. Kind of Bu	>iness/indus	• 1
2121	I within liene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	OME M	JAKER		0 W	NC _	HOME
	be filed within 72 hours after death with the Marylan ital Hygiene. Id other than "naturel; or Items 23a or 28a-f show event, the Medical Enditinet must be notified at	BeC	17. Father's Name (First, Middle, Last)				e (First, Middle, Ma	aiden Sumam		
ylaı	should be ind Mental imarked o	To E	CHOU	FERGUSON	alling Address (Street	Macy	- LOuve Alumbar	_00	NHE	-
Maryland	nd 2 shoulth and 27 is m	-	19a. Informant's Name/Relationship (Ty.	- 1.0-		I VK) A				D 21221
_	a de est		20a. Method of Disposition	20b. Place of Dis	position (Name of rematory or other place		Date 20	0c. Location -	City or Town	n, State
OE .	Pages nent of int: If it		1 ☐ Burial 2 🗹 Cremation 3 ☐ R  1 ☐ Donation 5 ☐ Other (Specify)	temoval from State				PORESI		TIMD
Baltimore,	permit. Pages -Department of I Important: If it eny injury or o		21. Signature of Funeral Service License		22. Name and Addre	ss of Facility		LIERN		_
	80 E 2 9			ications that caused the death. Do not e		RK KD.	or resouratory arres		A	21673
			shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.	)	19, 54017 45 54. 4145				nterval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a consequence of):	encer				_	
В	Examiner		Sequentially list conditions,	b						,
	p #	iner	if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):						
	xecute and and	Examine	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):						
160	eath certilicate be executed attending physician and for use as the burial-transit	icai E		d						
89	rtificat ng phy as th		IF FEMALE:							<u> </u>
Вох	death certifica e attending ph id for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months?		3 □Ectopic pregnanc 5 □ Other (specify) _	у		23d. Date Mor	te of delivery nth Da	ay Year
0.	0 0	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐ Pregnant at time of death 9☐ Unknown	5 Li Ottier (specify) _					
s, P.	requires that the seen signed by th hould be detach	by Ph	Part II. Other significant conditions co	ntributing to death but not resulting in the	e underlying cause gr	ven in Part I.	23e. Did toba			cause of death?
rds	w requires been sign should be						1 🗌 Yes	s 2 No	3 Probab	oly 4 Unknown
Record	aw 1s t	ompleted					24a. Was an autopsy	,   0	Were autops prior to comp death?	sy findings available pletion of cause of
	The ate h	Con					perform 1 Yes 2	<b>□</b> ₩6 1	Yes 2	□ No
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpat	tient 3 DOA Ott	hoc	th (Check only one ome 5 Nesider		or (Consilu)	-
of		1: To	1 ☐ Yes 2 ☑ No ☐ 27. Manner of Death	28a. Date of Injury 28b. Time	e of 28c. Inju	ry at	28d. Describe hov			
ion	Attending P	ation	1 ØNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Yeer) Injur	,	Yes 2□No				
Division	or Atterde after de Directo	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office		28f. Location (Stre City or Town,		er or Rural F	Route Number,
	pitel ours al		29a. Centifier 1 Certifying Phy	rsician: To the best of my knowledge, de	eath occurred at the ti	me, date and place	, and due to the cau	use(s) and ma	anner as stat	ted.
	To the Hospitel or Atte within 24 hours after de To the Funeral Directo completely filled in by th	Medical	(Check only 2 Medical Exami	iner: On the basis of examination and/or and manner stated.	r investigation, in my	opinion, death occu	rred at the time, dat	te and place, a	and due to th	he cause(s)
	To th withir To th comp	M	29b. Signature and little of certifier	1 1	29c. Licen	se number	29	d. Date signed	d (Month, Da	sy, Year)
	/		- LK	H	IMD	V0035	5094	3/2	3/05	-
	K		30. Name and advess of terson who co	ompleted cause of death (Item 23a) (Typ	pe, Print)	c II de	ine Ho	with/	2	
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature	N.	- Achi	VIS	The		-
	Regist		MAR 2 5 2005	Blower St Agreet						

			1 - For State Registrar	State of N	Maryland / Dep <i>Ce</i>	artment of H			ene20	05	10167			
	Physici		Decedent's Name (First, Middle, La     JOSEPHINE	st)	F	OGLE		2. Date of Death Month 03	Day	Year 2005	3. Time of Death 2:15 A M			
	/Medic Examir		4a. Facility Name (If not institution, giv	e street and number			r Location of Deat	1	4c. County					
	Lxuiiii		MARINER HEALTH C	F FOREST	HILL	FOREST	HILL		HARI	ORD				
	Funeral Director		5. Social Security Number 218-14-5939	ex 7 ☐ M 2☐ F	Age (In yrs. last birthday 85 Yrs.	If Under 1 Year   Months   Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Dec. 22,	1919	Count	lace (State or Foreign try) Land			
	pur 🛦 🖂		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation		-		10	0d. Inside City Limits			
	Aaryla I sho	ŏ	Md. Harfor	rd		Abingdon					1 ☐ Yes 2 ☐ No			
	28e-	Director	10e. Street and Number	Lu		10f. Zip Code		10	g. Citizen of W	hat Count				
	h with		313D Laurel Wood	ds Drive		210	09		U.S.A.					
980	be filed within 72 hours after death with the Maryland tial Hygiene. d other than "natural", or items 23e or 28e-f show of other than "natural", or items 25e or 28e-f show event. I'm Medical Examina must be notified at	by Funerai	11. Marital Status  1 Never Married 2 Married  3 XWidowed 4 Divorced	12. Was Decede Armed Force 1 Tyes 25 If Yes, Give Year or Date:	s? ⊒No	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No- to Rican, etc.)		- Amenca k, White, e whi	etc.			
Maryland 21215-0036	"natur	Completed	15. Decedent's E (Specify only highest gra		16a. Dece (Giv.	edent's Usual Occup e kind of work done o DO NOT use retired	ation during most of wor	rking	6b. Kind of Bu	siness/Ind	ustry			
12	within 72 ene. than "nai	duic	Elementary/Secondary (0-12) 12 years	College (1-4d	homen		")		own 1	10ma				
9	filed Hygi other	Be Co	17. Father's Name (First, Middle, Last,	)	Homen	akel	18. Mother's Nar	me (First, Middle, M.						
<u>la</u>	should be nd Mental marked o	ToB	Paul Vigliato				Jenny	Salamone						
lar)	2 should and Men Is marke eumetic		19a. Informant's Name/Relationship (	** *		ing Address (Street					_			
	as 1 and 2 should by Health and Ment Item 27 is marked rother treumetic s			nephew			Kun Koad							
JOLE	t. Page tment rtant: II		1 Burial 2 ☐ Cremation 3 ☐		te cemetery, cre	matory or other plac	1							
Baltimore,		1				2. Name and Addres	ss of Facility							
ñ	Departing Department of the police once.		John McTaggart/nephew  20a. Method of Disposition  1											
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caus one cause on pach	sed the death. Do not en line.	ter the mode of dyin	g, such as cardiac	or respiratory arres	st,		Approximate Interval Between Onset and Death			
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. A ?	sheimer	s ler	nente	-		T	W VOAV			
	/Medical Examiner		resulting in death)	Due to (er.	as a consequence of):					1	/			
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	cuted nd ransit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c										
ő,	icate be executed physician and s the burial-transit		resulting in death) Last	Due to (or	as a consequence of):									
8760,	physic the b	dicai		_ d										
.O. Box 6	requires that the death certificate be executed een signed by the attending physician and hould be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregpent in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetel death 3 at time of death 5	□Ectopic pregnancy □ Other (specify)			23d. Date Mon	of deliver th	ry Day Year			
<u>α</u>	s that i	by Ph	Part II. Other significant conditions of	contributing to death	but not resulting in the	underlying cause give	en in Part I.	23e. Did toba	icco use contri	bute to the	e cause of death?			
rds	w requires been sign should be		Aspiration	- Ine	umonia			1 🗆 Yes	2 15 No	3 Proba	ably 4 □Unknown			
Records,	sicien: The law requ certificate has been rector, page 2 shoul	Completed	Cerebro Va	scular	- Acad	ent_		24a. Was an autopsy performs	ed? pi	/ere autoprior to comeath?	osy findings available apletion of cause of			
Vital	sicien: certifica rector,	Be (	25. Was case referred to medical examiner?	11		0.4		ath (Check only one,	)					
of/	Physicien: this certific ral director,	10 10	1 Yes 2 No	Hospital: 1 ☐ Inpa 28a. Date of Ir		-	wursing H	lome 5 Residen			)			
OU	ding After fune	tion	Natural 5 Pending 2 Accident investigation	(Month, I	Day Year) Injury	Work	(? Yes 2 □ No	200. 0030100 110%	william cooding					
Division		Certification;	3 Suicide 6 Could not b determined	e 28e. Place of	Injury - At home, farm, setc. (Specify)	reet, factory, office		28f. Location (Stre City or Town,		r or Rural	Route Number,			
	Hospita 4 hours Funerel	edicai C			st of my knowledge, dea									
	To the within 2 To the complete	Me	29b. Signature and title of certifier	3.13.77411101		29c. License	e number	290	d. Date signed	(Month, D	Jay, Year)			
	4			1-		Dio	503	1	barch	21	,2115			
	h.		30. Name and address of person who								1-003			
	<i>y</i>		DR. MANUEL LAZAT		STREET, A	BERDEEN, N	4D 21001	<u> </u>						
7	Sta Registr		31. Date filed (Month, Day, Year)  MAR 2 5 2	005	strar's Signature	redi								

				State of	Maryla	•	artment of <i>rtificate of</i>		d Mental H	ygiene Reg. No. 2	105	10100
		1. Decedent's Name (First,	Middle, Las	1)					2. Date of E	Death		3. Time of Death
	Physician /Medical	DOWALL		James		Fe	rguson S	r.	Month	Day	Year lous	SIRSAM
The same of the sa	Examiner	An Challing Name Of and Inc.	itution, give	street end nun	nber)			4b. City, Town,	or Location of Dec	eth 4c. Coun	nty of Death	
		Universty	Speci	alty Ho	spita	1		Baltin		N.		
	Funeral Director	5. Social Security Number 218–58–9398	6. Se	x □M 2□F		s. last birthday) 52 Yrs.	Months Days		lin. 8. Date of E (Month, L Feb.	in. (Month, Day, Year) Country)		
-	pu &	Usuel Residence of Decede  10a. State 10b. C			100 (	City, Town or Lo	cation				1.	Od. Inside City Limits
	faryls ahor		timor	۵			Quarter	c				1 ☐ Yes 2 🎇 No
	ith the Mar or 28s-f a	10e. Street end Number				DOWICYS	10f. Zip Code			10g. Citizen o	f What Cour	
	With the state of		0	11 - 1	D 1							my:
	ifter daath ver teme 23 ver them to 23 ver teme 23 ver	358 Apt. C.	Carro	12. Was Dece	dent Ever in	U,S. 13. V	21220 Was Decedent of		(Specify Yes or Nerto Rican, etc.)		S.A. ace - Americ	can Indien,
Baltimore, Maryland 21215-0020	pomnit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiena. Department of Health and Mental Hygiena. Introortant: if Item 27 is marked other than "natural; or items 23a or 28a-f ahow any Injury or other traumatic event, the Medical Examinar must be notified at once.  To Be Completed by Funeral Director	1 ☐ Never Married 2 ☐ 3 ☐ Widowed 4 ☐ Div	-	Armed For 1 Yes If Yes, Give Year or Da	2√E] No		fYes, specify Cu I□Yes 2√⊡No		erto Rican, etc.)	Spec	lack, White,	etc. ite
ŏ	2 hou		edent's Edu			16a. Deced	lent's Usual Occu	pation		16b. Kind of		
3	ed within 72 ho ygiena. Per than "natur. It, the Medical. Completed	(Specify only I		e completed) College (1	-4or 5+)	(Give	kind of work done OO NOT use retir	e during most of ( ed)	working			-
7	d with a gienze	8		NA.		Carpo	enter			Contra	cting	
p	al Hy	17. Fether's Name (First, Mi	ddle, Last)			_		18. Mother's N	lame (First, Middi	le, Maiden Sume	eme)	
₹	should be fit nd Mental H marked oth umafic even To Be	Louis				Ferguson	n	Ardel			Mil:	ler
Mar	12 sh nand nand nand reum	19a. Informant's Name/Rela	tionship (T	rpe, Print)		19b. Mailin	g Address (Stree	nt and Number or	Rurel Route Num	ber, City or Tow	n, State, Zip	Code)
a)	1 and Health em 27 ther tr	Howard J. Fer	guson	<u>Jr. (S</u>	ion)	3443	Yorkway	Baltimo	re, Mary	1and 21 20c. Location		num Stato
و	Pages nent of I unt: if Ite ury or o'	1 ⊈Burial 2 ☐ Crema			otate		sition (Name of natory or other pl		March		•	
	it. Pr intme injury	4 Donation 5 Oth			Pa		Cemete:		24,2005	Baltimo	ore, M	Maryland
Ba	permit. F Departme Importan any Injur	> Mark	A	hin-	1100	Pa-			ojnacki e. Balti			
		23a. Part1. Fiter the disease shock, or heart failure.	se, or compl List only o	ications III it ca ne cause on ea	used the de	ath. Do not ente						Approximate Interval Between
7	Physician											Onset and Death
	/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	,	a	Comr	il cation	15	C3 -	cs Fr	active		
	in the same of				Due to	(or as a conseq	uence of):				1 1	
	axecuted in and rial-transit			b	Duate	(or as a conseq				-	1	ME
0	fficate ba axecuted 3 physician and as the burial-transit edical Examir	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying			Due to	(or as a consequ	delice oij.			ON APP OVED BY	DICAXERAN	ur.
68760,	ficate ba a physician is the buri	Cause (Diseese or injury that initieted events resulting in death) Last	5	o	Due to	(or as e consequ	uence of):		$\sim$	WED BY		
	ng pt ng pt sas ti	resulting in death) Last							1	ON APP	$X \vdash$	
Вох	ath ce ttendi or use			d					CERTIFICAT			
0	the a the a hed f	Part II. Other significent cor	nditions cor	tributing to dea	ath but not re	sulting in the un	derlying cause g	ven in Part I.	23b. bio	tobacco use c	ontribute to	the cause of death?
Division of Vital Records, P.O.	<ul> <li>The law requiras that the death certificate has been signed by the attending, page 2 should be datached for use a Completed by Physician/Me</li> </ul>								110	Yes 2□ No	3 ☐ Prob	pably 4 nknown
ds,	signed by								24a Wa	s an autopsy	24h We	ere autopsy findings
ò	requ been shoul								per	formed?	ava	ailable prior to mpletion of cause
ě	has ge 2	•							90 (04-04			death?
g	n: The ficate or, pa	25. Was case referred to me	rdical							Yes 2kg/No	1	Yes 2□ No
5	Attending Physician: In death.  ector: After this certification the funeral director, Iffication: To Be (	examiner?		lospital: 1 [10]	nationt 2	☐ ER/Outpatient	3 DOA 0	hor	eath <i>(Check only</i> Home 5 Res	/	that (Canain	d
<u></u>	y Phy erthis eral c	27. Menner of Deeth		28e. Dete of		28b. Time of	28c. Inju		28d. Describe	how injury occu	ırred	
<u></u>	athor e fun e fun	1 □ Natural 5 □ Po 2 □ Accident in	ending vestigation	The same of the same of	LOO-	Injury		Yes 2 □ No	subject	fell off	adder	
<u>S</u>	ar dan ecto by th	3 ☐ Suicide 6 ☐ C	ould not be etermined	28e. Place of		home, farm, stre	et, factory, office		28f. Location	(Street and Num	ber or Rura	l Route Number,
ַ ב	tal or Attanding P irs aftar daath. al Director: After t led in by the funers  Certification:						BUILDIN	4	7422 Br	iwn, State) USN field	Road	re, MD
Ì	To the Hospital or Attanding Physician: The law within 24 hours aftar death.  To the Funeral Director: After this certificate has completaly filled in by the funeral director, page 2.  Medical Certification: To Be Comp	29a. Certifier 1 Y Cer (Check only 2 Med	tifying Phys lical Exami	sician: To the bas ner: On the bas and mann	is of examin	owledge, death ation end/or inv	occurred at the ti estigation, in my	ime, date end pla opinion, death oc	ce, and due to the curred et the time	ceuse(s) and m	nann <i>e</i> r as ste	eted.
. '	vithin To th comp	29b. Signature and title of ce	ortifier				29c. Licen	se number		29d. Date sign	ed (Month, I	Day, Yeer)
		1					D 3	6494		3123	105	
	17	30. Name end address of pe	rson who co	mpleted cause	of deeth (Ite	sm 23a) (Type, F	Print)				0 1	
		KDESAIN					y haspit	-/ 60/	south c	horles st	-1391	timene mp
ń.	State Registrar	31. Date filed (Month, Day, )		32. Re	gistrer's Sigr	nature	d.					

DHMH 16 Rev 6/95

Howard James Ferguson

	For State Registrar  1. Decedent's Name (First, Middle, Last)	State of Maryland / Dep	ertificate of Death	2. Date of Death	g. No. 2005	0 6 3. Time of Death
sician ledical aminer	Alvin Edward  4a. Facility Name (If not institution, give s  10518 Vincent Roa	street and number)	4b. City, Town, or Location of Dea White Marsh	March th	21, 2005  4c. County of Deeth  Baltima	
eral tor	u.,	7. Age (In yrs. last birthday 7 Yrs.	y) If Under 1 Year If Under 24 Hrs Months Days Hours Min		year) 9. Birth Cou	place (State or Foreig intry) LYLAND
Director	Usual Residence of Decedent  10a. State 10b. County  Maryland Baltimo  10e. Street and Number	10c. City, Town or L	White Marsh	10	g. Citizen of What Cou	10d. Inside City Limits
al Dir	10518 Vincent R	oad	10f. Zip Code 21162	10	u.s.A	•
ompleted by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 N Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Xi Yes 2 Ng 945 – If Yes, Give Year or Dates: 1948	8. Was Decedent of Hispanic Origin? (solid Yes, specify Cuban, Mexican, Puel 1 Yes 2 💢 No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Ameri Black, White Specify:	
Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 10th Grade	cation 16a. Dec (Giv   Ife. College (1-4or 5+)	cedent's Usual Occupation we kind of work done during most of wo LOO NOT use retired) CELWOTRET		66. Kind of Business/Ir Steel Compo	
To Be Co	17. Father's Name (First, Middle, Last)  John Raymond G		18. Mother's Na	me (First, Middle, M aret Mari	aiden Sumame)	crity
т прите	19a. Informant's Name/Relationship (Ty) Mrs. Gina Mitchell	(daughter) 105	iling Address (Street and Number or A 18 Vincent Road,			
lury or oth	20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ R 1 □ Donation 5 □ Cher (Specify)		position (Name of ematory or other place) ill Mem'l Park 3/2		Oc. Location - City or T altimore,	
SDC8	21. Signature of Juneral Service License	90	22. Name and Address of Facility Sc 9705 Belaul Rd.,	chimunek F	uneral Hom	
an cal	23a. Part 1. Enter the disease, or complishock, or mart failure. List only on Immediate Cause (Find disease or cundition resulting in death)		enter the mode of dying, such as cardia			Approximate Interval Between Onset and Death 2 WCCKS
cal Examiner	Sequentially list conditions, if any, leading to numericate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):  Due to (or as a consequence of):				
/Medica	230. Was decedent pregnant		□ Ectopic pregnancy		23d. Date of deliv	
ysiclan	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at time of death 5 9□Unknown	Other (specify)		THE THE	ery Day Year
by Physi	1 ☐ Yes 2 ☐ No	9 Unknown	i ☐ Other (specify)		acco use contribute to t	Day Year the cause of death?
Completed by	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	i ☐ Other (specify)	24a. Was an autopsy perform	acco use contribute to to 2 No 3 Pro	the cause of death?  bably 4 Unknown  opsy findings available completion of cause of
To Be Completed by	1 ☐ Yes 2 ☐ No 9 ☐ Unknown  Part II. Other significant conditions	9 Unknown	underlying cause given in Part I.  26. Place of De ent 3 DOA Other: 4 Nursing of 28c. Injury at	1 Syes  24a. Was an autopsy perform 1 Yes 2	24b. Were autorior to code and?  24b. Were autorior to code and?  1 Yes  1 Other (Special	the cause of death? bably 4 Unknowr opsy findings available ampletion of cause of
by the funeral director, page 2 should be of ification; To Be Completed by	1 ☐ Yes 2 ☐ No 9 ☐ Unknown  Part II. Other significant conditions con  25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No  27. Manner of Death	9 Unknown  Itributing to death but not resulting in the death	underlying cause given in Part I.  26. Place of De ent 3 DOA Other: 4 Nursing of 28c. Injury at Work? M 1 Yes 2 No	1 N Yes  24a. Was an autopsy perform 1	24b. Were autorior to code and?  24b. Were autorior to code and?  1	Day Year the cause of death? bably 4 □Unknowr opsy findings available ampletion of cause of 2 □No
by the funeral director, page 2 should be diffication; To Be Completed by	1  Yes 2 No 9  Unknown  Part II. Other significant conditions cond	9 Unknown  attributing to death but not resulting in the death	underlying cause given in Part I.  26. Place of De ent 3 DOA Other: 4 Nursing of 28c. Injury at Work? M 1 Yes 2 No street, factory, office	24a. Was an autopsy perform  1 Yes 2  Path (Check only one 28d. Describe how 28d. Describe how 28f. Location (Street, City or Town, 28d. Describe how 28f. Location (Street, 28d. Locat	24b. Were autroprior to control of death?  1 Yes  24b. Were autroprior to content of the death? 1 Yes  1 Other (Special of the Content of the	the cause of death?  bably 4 Unknown  opsy findings available  ompletion of cause of  2 No  fy)  al Route Number,  stated.  to the cause(s)
al director, page 2 should be d	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death Natural 5 Pending investigation 3 Suicide 4 Homicide  29a. Certifier (Check only one)  29b. Signature and title of certifier	antributing to death but not resulting in the story of the last o	underlying cause given in Part I.  26. Place of De ent 3 DOA Other: 4 Nursing of 28c. Injury at Work? M 1 Yes 2 No street, factory, office	24a. Was an autopsy perform  1 Yes 2 in the Check only one  Home 5 K Resider  28d. Describe how  28f. Location (Strr. City or Town,  1 and due to the car  28d. and due to the car  29	24b. Were autroprior to control of death?  1 Yes  24b. Were autroprior to content of the death? 1 Yes  1 Other (Special of the Content of the	the cause of death?  bably 4 Unknown  opsy findings available  mpletion of cause of  2 ( No  ify)  al Route Number,  stated. to the cause(s)  Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year GRAY, JR **Physician** geor ge WASHINGTON Mouds 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NA BALTIMORE MARIS If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Month Day, Ya Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits If item 27 is marked other then "neturel", or items 23e or 28e-f show or other treumetic event, the Medical Ever, it as must be realised at BALTIMORE ¥ Yes 2 No MD Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number MONASTARY NZY Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: BLACK þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene.
7 Is marked other then "r ptary/Secondary (0-12) College (1-4or 5+) SANITATION NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be SR M. JORDAN Pages 1 and 2 should I GRAY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) , BALD. MD 21229 nt of Health a 155 S. MONASTARY 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Importent: If eny injury or once. 03.23.05 BALTO. MD MT. ZION 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee VAUGINAC: GREENE FUNERAL SERVICE 5151 BADO. NATI: PIKE, BALTO. MD 2 a BALTO. MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** curve /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Clease or in jury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Completed by Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day ŏ in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) ☐ Yes 2 ☐ No of Vital Records, P.O. the 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 1 Yes 2 - No or Attending Physicien: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Inpatient 2 | EP/Outpatient 3 | DOA 1 ☐ Yes 2 ☐ No 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manger of Death Division Injury 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No s after death. investigation 2 Accident in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a **To the Funerel I**completely filled Hospitel 🗗 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 311812005 M 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) 301 57 Riseber

State Registrar 31. Date filed (Month, Day, Year)
MAR 2 5 2005

92. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** ELORE 2005 MAN Ch /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CCO 8. Date of Birth (Month, Day, NIA 1405 If Under 1 Year 7. Age (In yes. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Year) 1 ☐ M 2 🕱 F Months Days Hours Min. 219.40.2548 MD Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show must be notified at MD Baltimore Funeral Director 1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō Load Hillwell or Itams 23a 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. treumatic avent, it a Modical Examiner ☐Yes 2 No f Yes, Give 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 SNo Specify: Be Completed by 3 ☐ Widowed 4 S Divorced Year or Dates: 'netural', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Health Care Nurse 12th grade NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) la marked of Pages 1 and 2 should be S. Torell Duise 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Zelda 5216 Hillweil R Baltimore MD Gate other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Surial 2 Cremation 3 Removal from State ö Department of Important: If any injury or Baltimore, MD Arbutus \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signal re of Fune a Service License 23 Name and Address of Facility Vanglin C. Greene Funeral Services SIST Baltimore National Pike Balto. MD 21229 au 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical Due to (or as a cons **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last by Physician/Medical Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, the IF FEMALE esn 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ঠ in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) of Vital Records, P.O. detached 9 Unknown 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hinknown director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 1NO 25. Was case referred to medical examiner? 26 Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 3□ DOA 28a. Date of Injury (Month, Day Year) in by the funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation after death. 2 🗌 No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funeral L To the Hospitel 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DOO29968 MARCH 20, 2005 BALTIMORE, MANYLAND State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 5 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . <sup>Day</sup> 2005 March 22, **Physician** JANICE LUCILLE GAEGLER 3:10P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center Towson Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Min. | Min. | June 14, 1937 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 V 216-34-4093 67 Maryland Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Exeminer must be notified at 1 □ Yes 2 No Director Maryland Baltimore Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15 Warren Common 21030 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify ð 3 ☐ Widowed 4 ☐ Divorced Year or Dates: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education
(Specify only highest grade completed) 16b. Kind of Business/Industry Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Nursery & Landscape h and Mental Hygler 7 Is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Roy Edward Dukes Evelyn Hanaway Little 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Depertment of Health ar important: if item 27 1s Darlene Harenberg P<sub>0</sub>A 2822 St Paul St Baltimore, Maryland 21218 other t Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial XXCremation 3 ☐ Removal from State ö 4/□Donation 5 □ Other (Specify) GreenMount Cemetery 3/24/05 Baltimore, Maryland Sgnature of Funeral Service Licenses 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc. Kenakes ennis 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Breast cancor Physician Years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner burial-transit Due to (or as a consequence of) physician Physician/Medical as the t attending Box IF FEMALE: BSI 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Vear Day 5 ☐ Other (specify) 4 Pregnant at time of death the detached o 9 Unknown 9 Unknown been signed by م Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 Yes 2 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 certificate has autopsy 2 **A** No 1 ☐ Yes Vital director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence Other (Specify) 2 1 ☐ Yes 2 ☑ No Jo this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After Certification: Division or Attending 5 Pending Natural death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I Hospital 29a. Certifier Centifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie March 22 2005 58303 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) and 6601 N. Charle St Baltrine in 21204 Agrons CHAMES 31. Date filed (Month, Day, Year) 32, Registrar's Signature State MAR 2 5 2005 Registrar

gaeglea

			State of Maryland /	Department of Health and M	•	•
			1 - State Registrar  1. Decedent's Name (First, Middle, Last)	Certificate of Death	Reg. N	
	Physici /Medic	al	JAMES LESLIE HARVEY SR.  4a. Facility Name (If not institution, give street and number)		MARCH 8	3. Time of Death 2:15P. M
	Examin	er	9712 CROSS ROAD	4b. City, Town, or Location of Death		c. County of Death
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last to	Vrs Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	
	Director		Usual Residence of Decedent	wn or Location	Sept 17,	1921 MARYLAND  10d. Inside City Limits
	e Maryli Sa-1 sho	Director		RRY HALL		1 ☐ Yes 2½ No
	h with th	ai Dire	9712 CROSS ROAD	10f. Zip Code 21128		S. OF A.
920	72 hours after death with the Maryland natural; or Items 23a or 28a-f show deat Exacting rest by multified at	by Funerai	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S.  Armed Forces?  1 Never S 2 No 1 9 4 4 If Yes, Give Year or Dates: 1 9 4 6	13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1  Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: BLACK
21215-0036	Jwithin 72 ho piene. r than "natu It e Medical	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	a. Decedent's Usual Occupation (Give kind of work done during most of working infe. DO NOT use retired)	ing	Kind of Business/Industry
	Hyg Hyg ithe		17. Father's Name (First, Middle, Last)	GENERAL FOREMAN  18. Mother's Name	(First, Middle, Maide	RAILROAD en Sumame)
Maryland	0 to 0	To Be	CHARLES I. HARVEY (DECEASED	,		DECEASED)
Ma	d 2 s th ar 7 is			9b. Mailing Address (Street and Number or Rura 9712 CROSS ROAD PE		
nore,	e ° = 5		20a. Method of Disposition  X Burial 2 Cremation 3 Removal from State	of Disposition (Name of tery, crematory or other place)	71 2 / 0 5 20c.	Location - City or Town, State  IMONIUM, MARYLAND
Baltimore,	permit. Pag Department Important: I any injury o		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee  LEWIS T. GWYNN	LEWIS T. GWYNN FU	UNERAL H	OME 21215-6393
	Pnysician		23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition		or respiratory arrest,	BALTO MD Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)  a		away	4 years
1760,	te be executed ysician and burial-fransit e burial-fransit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to for as a consequence consequence.			
.O. Box 687	death certifica e attending ph d for use as th	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal dea 4 □ Pregnant at time of death	th 3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year
٥.	The law requires that the ste has been signed by the bage 2 should be detache	by	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.		o use contribute to the cause of death? 2 DNo 3 Probably 4 Dunknown
al Records,		Completed			24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ N	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
Vital	Phyaician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?  Hospital:	26. Place of Death		
of	ding After fune	tion: To	27. Manner of Death  1 Inpatient 2 EP/C  28a. Date of Injury (Month, Day Year)	Subation 30 DOX 40 Nursing No.	me 5 🔀 Residence 28d. Describe how inj	6 □Other (Specify) ury occurred
Division	deat deat ctor: / the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At home, building, etc. (Specify)		28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
	To the Hospital or A within 24 hours after To the Funeral Directorpletely filled in by	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowled 2 Medical Examiner: On the basis of examination and manner stated.	ge, death occurred at the time, date and place, a and/or investigation, in my opinion, death occurre	and due to the cause( ed at the time, date a	s) and manner as stated. nd place, and due to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	29c. License number  D45390		rate signed (Month, Day, Year)
,	7+1		30. Name and address of person who completed cause of death (Item 23a MYO WIN(M.D.) 8114 Sounds).			
	Sta Registi	7.	30. Name and address of person who completed cause of death (Item 23a MYO MIN (M.D.) 81(4 Sound).  31. Date filed (Month, Day, Year)  MAR 2 5 2005	Spark		
		Id.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1-Registrar AMEND ITEM #20b PER FH G841 Certify to State Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Karen Patricia Hubbard 07:28 AM 2005 /Medical 4a. Facility Name (If not institution, give street and number)
Schau Hastitzel of Battinuore 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore LISTICIZAN N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 287 F 50 1955 Maryland Director 217-64-6165 10, Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits the Medical Examiner must be notified at XXYes 2 ☐ No Directo Baltimore Maryland N/A10f. Zip Code 21215 10e. Street and Number 10g. Citizen of What Country? 4220 W.ROgers Avenue USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes X☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 ŏ 1 Yes 2 No Specify Black Š 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within 7 th and Mental Hygiene 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elizabeth Lucas Richard William Hubbard, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s nent of Health ar 4220 W. Rogers Ave Baltimore, Maryland21215 Elizabeth Hubbard/ Mother item 27 Baltimore, 20b. Place of Disposition (Name of cometery, cremator profit (Name of Woodlawn 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: if it any injury or o 1 

Burial 2 

Cremation 3 

Removal from State ' 4 □ Donation 5 □ Other (Specify) 3/21/05 Woodlawn, Maryland 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, Md 21215 21. Signature of Funeral Service See 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, allow, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PNEUMONII **Physician** week /Medical Due to (or as a consequence of): **Examiner** BACTERIA TAPHYLOWCCAL week Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). CO C\_1 The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. attending physician Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 4☐Pregnant at time of death 9□ Unknown 9V Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an 1M Yes 2 No or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 Z No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA this neral Director: After the filled in by the funeral 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Injury at Work? Natural 5 Pending investigation death. 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a

To the Funeral C the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medicai and manner stated 9 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MSBS REI - 000 16,2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MBBS 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 2 5 2005 Registrar

Losian

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			For State Registrar		State of	f Marylan		artmen rtificate			and Me	•	giene Reg. Ne	005	To the same of the	75
	Physici	an	1. Decedent's Name (F			II d a la a						2. Date of De Month March		O F Year	3. Time of	
	/Medic	al .	Helen  4a. Facility Name (If no	Mar		Hicks		4b. City.	Town, or	Location of		March		unty of Death		+ PM
	Examin	er	Suburban						heso					ontgom		
	. Funeral Director		5. Social Security Numl	108 1	ex □ M 2 1 F	7. Age <i>(In yr</i> s. 83	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours		B. Date of Bir (Month, Da une 4,	th 1921	Got	place (State o intry) SOURI	r Foreign
	land		Usual Residence of De 10a. State 10	b, County		10c. Cit	y, Town or Lo	cation							10d, Inside Ci	ty Limits
	Mary a-f sh	tor	MD	Montgom	ery	Ro	ckvill	.e							1 🗆 Yes	2 <del>X</del> No
	or 28	Funeral Director	10e. Street and Number		-			10f. Zip						of What Co	untry?	
	eath w	erai	15205 Ca	naytuit		dent Ever in U	S 13 V	208		isnanic Ori	ain? (Snec	ify Yes or No	USA 14	Race - Amer	ican Indian	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, If a M. Jirol Examinational Examination once.	by Fun	1 ☐ Never Married  3 ☑ Widowed 4 ☐		Armed Fo 1 Tes If Yes, Giv Year or Di	rces? 2 D No re X		If Yes, spec		n, Mexicar Specify:	i, Puerto R	ify Yes or No ican, etc.)		Black, White		
21215-0036	72 hou	eted		. Decedent's E			16a. Dece	dent's Usua kind of wor	I Occupa	ation	t of working		16b. Kind	of Business/l		
21	vithin 7	Completed	Elementary/Seconda		College (1	-4or 5+)	life.	DO NOT us	e retired	)		9	Desde	D		
d 2	filed v Hygie ther t		17. Father's Name (Fire	st, Middle, Last,	4+		ре	ntal	ASSI			(First, Middle,	L	ate Pr	actice	
lan	uld be lental rked o	To Be	Charles	Walter	Downard					Cec	eila	Gorfor	th			
Baltimore, Maryland	2 shou and N is mai		19a. Informant's Name	Relationship (	Type, Print)		19b. Mailir	ng Address	(Street a	and Numbe	er or Rural	Route Numbe	ər, City or To	wn, State, Z	p Code)	
e, S	s 1 and 2 of Health a item 27 is other trau	1	Nancy Hi 20a. Method of Disposi		cuso -		I 1:			ytuft	: Lane	Rocky		MD 20 ion - City or 1		
nor	ages of the first		XXBurial 2 □ C	remation 3		State	nce of	natory or or	ther plac		Marc	h 22,			rings,	77 A
altin	nit. Partme bartme cortan: injury	- 1	`4 □Donation 5 ( 21. Sign ure of Funer	-		~ ()	22	2. Name an	d Addres	s of Facilit	ty	005	OIN	mey b	nings,	VA
ä	Per and Per an		Jalen	1.120	Delect	22		ellin Main S				ome kson,	Virgir	nia		
П		/	23a. Parth. Enter the c shock, or heart fa	disease, or com illure. List only	plications that c one cause on e	aused the deat ach line.	h. Do not ent	er the mode	e of dyin	g, such as	cardiac or	respiratory a	rrest,		Approximate Interval Bety Onset and D	мөеп
	Pnysician /Medical		Immediate Cause (Fin disease or condition resulting in death)	al	a	teremia									1 Day	
	Examiner					orasa conseq sepsi	uence of);								1 Day	7
		Jer	Sequentially list condit if any, leading to imme cause. Enter Underlying	ions, diate	D	or as a conseq	uence of):									
	and transi	Examine	that initiated events resulting in death) Last	92	C								_			
8760,	icate be executed physician and s the burial-transit		, , , , , , , , , , , , , , , , , , ,		Due to (	or as a conseq	derice cr).									
9	ificate g phys as the	edicai			_ d											
Вох	death certificate be executed to attending physician and of locuse as the burial-transit	ićian/M	IF FEMALE:  23b. Was decedent print the past 12 mo  1 ☐ Yes 2 ☒ N	nths?	4☐Pregn	irth 2 ☐ Feta ant at time of d	Ideath 3□	Ectopic pro					23d.	. Date of deliv Month	,	'ear
P.O.	The Park	Physi	9 🗆 Unknown		9□ Unkno											
	law requires that as been signed I	by	Part II. Other significa	nt conditions o	contributing to de	eath but not res	utting in the u	nderlying ca	ause give	en in Part I.			obacco use o ∕es 2□N		the cause of debably 4 DU	eath? Inknown
Vital Records,	0 = 00	ошо										24a. Was autop perfo 1 Yes	rmed?	4b. Were aut prior to co death? 1 ☐ Yes	opsy findings a impletion of ca 2 No	avariable ause of
/ital	ysician: The is certificate director, or of	BeC	25. Was case referred examiner?	to medical	I I itali						of Death (	Check only o				
of	Phys this aldi	Ĕ	1 ☐ Yes 2 No 27. Manner of Death		Hospital: 1 💢	npatient 2  of Injury	ER/Outpatier		8c. Injury	4 🗆 140		e 5 Resid			fy)	
on	ding After fune	ation:		S ☐ Pending investigatio	(Mon	th, Day Year)	Injury	М	Work	<br Yes 2 □ I			,,			
Division	in Direct	artific		Could not b determined	200. Flace	of Injury - At hong, etc. (Specif	ome, farm, str	eet, factory	, office		28	3f. Location (5 City or Tox		umber or Rui	al Route Numb	бөг,
	A T T P	edical C			nysician: To the niner: On the ba and man											
	within 2 To the I	Me	29b. Signature and title	of certifier	0-	>0 (	$\gamma$	29c	License	number				gned (Month,	Day, Year)	
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7	O I	7	30. Name and address			e of death (Iter 9 Congr			me d	£400	Roote	wi 11a	MD 20	1852		
	Sta	ate	A. Rajva 31. Date filed (Month,	Day, Year)				ıaı Lö	1116 7	1407	RUCK	v T T T C 9	1111 20			
24	Regist		MAR 25	2005	State 32. R	S. B	Carles !									

State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month March 17, **Physician** 2005 Juan Harris 3:10 PMM /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Cheverly Prince George's Medical Center Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 6. Sex **Funeral** Months 1 № M 2 □ F 32 Oct 4, 290-70-8066 Ohio Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County "natural", or Items 23a or 28a-f ahow the Medical Examiner roust be notified at DC Washington 1 Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 627 L. Street NE Funeral 20017 USA death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ XNo If Yes, Give within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: black þ Year or Dates: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) mit. Pages 1 and 2 should be filed within nartment of Health and Mental Hygiene. ortant: If Item 27 Is marked other then 'injury or other traumatic event, the Ms injury or other traumatic event, Elementary/Secondary (0-12) College (1-4or 5+) social worker <del>hospital</del> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Frank Harris Donna Hargrove 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Frank Harris/father 1106 Hillcrest Road Cincinnati, OH 45224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 3 Removal from State 1 Burial 2 Cremation permit. Page Department of Important: If any injury or once. 4 □Donation 5 X Other (Specify) in State 21. Signature of Funeral Service Licensee Wade State MANdersmy Board 655 W. Baltimore Street Director Baltimore, MD 21201 much del 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 1MMWOSUFFRESSIVE **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attanding Physician: The law requires that the death certificate be executed for use as the burial-tran and Due to (or as a consequence of): P.O. Box 68760. attending physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) should be detached the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2XNo Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Whas an page 2 autopsy performed 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 1 ☐ Yes 2 No 1 K inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Natural 5 Pending Injury thours after death. uneral Director: Af 1 ☐ Yes 2 ☐ No investigation 2 Accident To the Within 24 hours within 24 hours within 24 hours with 10 the Funeral Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 48042 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Green be) Muryland Sarfaraz writual 1 tanover chammad 32 Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 2 5 2005 faste Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** James Edward Hayes 2005 0448 March 4a. Fecility Name (If not institution, give street and number) /Medical 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimere
If Under 1 Year | If Under 24 Hrs. Saint Agnes
5. Social Security Number Healthcare N/A 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Months Hours Min. 1 XM 2 ☐ F Yrs Director 220-24-0698 04 - 25 - 1931Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d, Inside City Limits itam 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Mcdical Examiner must be notified at 1 Yes 2 No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3505 Georgetown Rd. 21227 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 2 Yes 2 No If Yes, Give 2 2 3 1 - 53 Year or Dates 2 - 3 1 - 53 1 ☐ Never Married 2 A Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed withinnent of Health and Mental Hygiene.
ant: If itam 27 Is marked othar than ury or othar traumatic event, Ine M Fork Lift Operator Canning 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John C. Hayes Teresa Bowman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Delores Ruth Hayes/Wife 3505 Georgetown Rd. Baltimore MD 21227 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Meadowridge Memorial
Park 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. 3-28-2005 4 Donation 5 ☐ Other (Specify) Dorsey, Maryland 21. Signalule y Funeral Service License 22 Name and Address of Facility Ambrose Funeral Home of Lansdowne Lansdowne MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final Physician Acute myccardial
Due to (or as a constituence of): disease or condition resulting in death) /Medical **Examiner** poxia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to r s a consequence of): Examiner attending physician and for use as the burial-transit Due to (o as a sequence of): 3 years carringmo Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Frobably 4 ☐ Unknown Chronic obstructive pulmonary disease 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an diabetes mellitus autopsy performed? certificate 1 Yes 22 NO Diractor: After this certification in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 32 DOA 1 ☐ Yes 2 ☐ No P o 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: or Attending 1 DNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide within 24 hours a
To the Funeral (
completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier 30. Name and address of person who completes cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

D

State

31. Date filed (Month, Day, Year)

MAR 2 5 2005

COMPS

32. Registrar's Signature

022648

Snyder M.D. 900 South CATEN Avenue Baltimore, MARYLAND 21229

MARCH 24, 2005

			For State Registrar	State of Maryl		artment of H rtificate of L			jiene 109. No 2005	10178			
ı	Physicia /Medic		1. Decedent's Name (First, Middle, Last)	uhbard	JR.			2. Date of Dea Month	th Day Year	3. Time of Death			
}	Examin Funeral Director		4a. Fecility Name (If not institution, give s How dord Garder 5. Social Security Number 6. Sex 218 - 18 - 3434	15	vrs. last birthday, 94 Yrs.	4b. City, Town, or Column If Under 1 Year Months Days	> the	8. Date of Birth (Month, Pay	(Year) Cou	plece (State or Foreign			
	show a a		Usual Residence of Decedent 10a. State 10b. County	10c.	. City, Town or L	ocation			7	10d. Inside City Limits			
	with the Ma a or 28a-f	Director	MARYLAND N/A 10e. Street and Number		BALI	10f. Zip Code		1	10g. Citizen of What Cou	tyYes 2□No ntry?			
36	be filed within 72 hours after death with the Maryland ntal Hygiene. The control of other than "natural", or flems 23a or 28a-f show event, it is Medical Examinat must be notified at	by Funeral	2121 WINDSOR GAR  11. Marital Status  1 Never Married 2 Married  3 Widowed 4000 Divorced	DEN LANE  12. Was Decedent Ever in Armed Forces?  1XX Yes 2 \( \subseteq \text{No li Yes, Give Year or Dates: 42.} \)		Was Decedent of His If Yes, specify Cubar		ecify Yes or No- Rican, etc.)	U.S.A.  14. Race - Ameri Black, White,  Specify: BLAC	etc.			
21215-003	na na	Completed b	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation	16a. Dece (Give life.	edent's Usual Occupa e kind of work done d DO NOT use retired,	uring most of work	ing	16b. Kind of Business/Ir				
Maryland 2	should be filed withir Mantal Hygiene. Marked other than Imatic event, the Man	To Be Co	unknown  17. Father's Name (First, Middle, Last)  ELLIS HUBBARD SR		MEC	CHANIC	18. Mother's Name		AUTO Maiden Sumame)				
_	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 9008.		19a. Informant's Name/Relationship (Ty, Ellis B. Hubbard II 20a. Method of Disposition	I/Daughter	539 F		nd Number or Run ., Baltin	al Route Number More, Ma	r, City or Town, State, Zince 17, City or Town, State, Zince 17, City or Town, State, Zince 17, City or Town, City	.7			
Baltimore,	mit. Pages vartment of l ortant: If it injury or o		NXBurial 2 Cremation 3 R 4 Donation 5 Other (Specify) 21. Signature of Funeral Septime U. Sep	emoval from State	Cometery, cre GARRISON	TOREST  2. Name and Addres	03-29	9-05	OWINGS MILI	S, MARYLANI			
ä	permit. Departiments Imports any inj		21. Signature of Funeral Septing Lifeston  22. Name and Address of Facility  WILLIAM C BROWN COMMUNITY FUNERAL HOME  1206 W NORTH AVENUE  23a. Part, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
- 3	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to for as a con	ation esequence of):	ma	emenia	a estat	L_ 0,	Onset and Death			
58760,	cate be executed physicien and the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a con	sequence of):		0						
P.O. Box 68	The law requires that the death certifical to has been signed by the attending phroage 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pre 1 □ Live birth 2 □ I 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of deliv Month	ery Day Year			
	w requires that been signed b should be deta	by	Part II. Other significent conditions ear	Hibuting to death but not	1	underlying cause give	on in Part I.	23e. Did to	bacco use contribute to the second se	he cause of death?			
al Reco		Completed						24a. Was a autopo perfor	med? prior to co	opsy findings available ompletion of cause of			
Division of Vital Records,	nding Physician: The lav th. : Atter this certificate has funeral director, page 2	ition: To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death  Natural 5 Pending investigation	lospital: 1 ☐ Inpatient  28a. Date of Injury (Month, Day Yea	2 ER/Outpatie	of 28c. Injury Work	4 Al Nursing Ho	ome 5 Resid	ne) ence 6 □Other (Speci ow injury occurred	(y)			
Divisi	To the Hospitel or Attending Phwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - , building, etc. (Sp	At home, farm, s	treet, factory, office		28f. Location (S City or Tow	treet and Number or Run n, State)	al Route Number,			
	the Hospi hin 24 hour the Funer npletely fill	Medical	(Check only one) 2 Medicel Exami	sicien: To the best of my ner: On the basis of exam and manner stated.	knowledge, dea mination and/or i	nvestigation, in my or	pinion, death occur	red at the time, o	date and place, and due t	o the cause(s)			
)	T. W. T.		29b. Signature and type of certifler	mo-	6	29c. License	2539		3-23. Date signed (Month,	-2005			
	24 1	to	30. Name and address of person who co	empleted cause of death	ignature	aven	. 18lv	4, 18	altimore	21239			
	Regist		MAR 2 5 2005	Berewa St.	Speed					,			

		1 - For State Registrar	e of Maryland / Depa <i>Cel</i>	artment of Health a	-	giene Reg. No. 201	15 1017		
Physic		1. Decedent's Name (First, Middle, Last)  Gladys Catherine	Jackson		2. Date of D Month March	eath	3. Time of Death 3:00 PM		
/Med Exami		4a. Facility Name (If not institution, give street at 4725 Homesdale Av		4b. City, Town, or Location Baltimo	of Death re	4c. County of Death N/A			
Funera Directo		5. Social Security Number  162-26-2947  Usual Residence of Decedent	7. Age (In yrs. last birthday) 73 Yrs.	If Under 1 Year If Under Months Days Hours	Min. (Month, D	9. B 4, 1931 Pe	irthplace (State or Foreign Country) ennsylvania		
ryland how		10a. State 10b. County	10c. City, Town or Lo				10d. Inside City Limits		
ith the Marylar or 28a-f show	ecto	Maryland N/A  10e. Street and Number		Baltimore 10f. Zip Code		10g. Citizen of What (	1 Yes 2 No		
h with 23e or	al Dir	4725 Homesdale Av	enue	2120	6	USA			
72 hours after death w naturel; or Items 23e	by Funeral Director	1 Never Married 2 Married 1 If Ye	ed Forces? Yes 2 17 No	Was Decedent of Hispanic Or If Yes, specify Cuban, Mexica 1 ☐ Yes	n, Puerto Rican, etc.)	Black, Wh	nerican Indian, nite, etc. Black		
	Completed	15. Decedent's Education (Specify only highest grade compl Elementary/Secondary (0-12) Coll 11th Grade	leted) (Give	dent's Usual Occupation kind of work done during mos DO NOT use retired)  Nurse	st of working	16b. Kind of Busines Cromwell Center	s/Industry l Nursing		
2 should be filed within and Mental Hygiene. Is marked other then reumatic event, the Mental Hygiene.	Be	17. Father's Name (First, Middle, Last)  Charles R. Smi	th		er's Name (First, Middle Edrena S	e, Maiden Sumame)			
2 should and Men is marke	2	19a. Informant's Name/Relationship (Type, Prin	t) 19b. Maili	ng Address (Street and Numb	er or Rural Route Numi	ber, City or Town, State			
C, IV		Gayle C. Moore/ Da  20a. Method of Disposition	ughter 4/25	Homesdale	Avenue Ba	11timore,			
permit. Pages 1 and 3 Department of Health Importent: If item 27 any injury or other tr		1 ☐ Burial 2 🌠 Cremation 3 ☐ Removal  4 ☐ Donation 5 ☐ Other (Specify)	from State cemetery, crei	natory`or other place) unt Cemeter	y3/25/05		e, Maryland		
Physician /Medica Examiner		Sequentially list conditions b.	that caused the death. Do not ent	240 Reister er the mode of dying, such as			Approximate Interval Between Conset and Death Conset and Death Conset and Death Conset and Death Conset and Death Conset and Death Conset and Death Conset and Death Conset and Death Conset and Death Conset and Death Conse		
To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Ves 2 No.		□Ectopic pregnancy □ Other (specify)		23d. Date of d Month	elivery Day Year		
uires that t i signed by Id be deta	b	Part II. Other significant conditions contributin	g to death but not resulting in the u	nderlying cause given in Part		tobacco use contribute	to the cause of death?		
The law requir	Completed				24a. Waa auto peri 1 🗆 Yes	opsy prior to formed? death?	autopsy findings available completion of cause of		
sicien:   scertifical	o Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital:	1 ☐ Inpatient 2 ☐ ER/Outpatie	Other	e of Death (Check only ursing Home 5		nacifu)		
nding Phy th.: After this stuneral d	<del> </del>		Date of Injury (Month, Day Year) 28b. Time o		28d. Describe	how injury occurred	Bolly		
To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the to	Certification:	a Could not be	Place of Injury - At home, farm, str building, etc. (Specify)	reet, factory, office		(Street and Number or I own, State)	Rural Route Number,		
te Hospite 24 hours te Funere	edical C	(Check only 2 Medical Examiner: On	To the best of my knowledge, deat the basis of examination and/or in d manner stated.						
To the within To the Comp	W	29b. Signature and title of certifier	Ma	D470	134	3 29 los	nth, Day, Year)		
Ol		30. Name and address of person who complete	d cause of death (Item 23a) (Type.	Print) Pur Puri	B. MAN	hund W	2		
S Regis	tate	31. Date filed (Month, Day, Year) MAR 2 5 2005	32. Registrar's Signature	Es .	420 VV.	riza			

			For State Registrar AMEND ITE	State of Ma	arylanc	1 / Depa 84206	artment of	Health a Hoeath	and M		giene Reg. No.	2005	10180
	التحص		Decedent's Name (First, Middle)							2. Date of Dea	ath Day	Year	3. Time of Death
	Physicia /Medic		Warren Francis	s Jenkins						March :		2005 Tear	12:30 P M
	Examin		4a. Facility Name (If not institution,	give street and number)			4b. City, Town,	or Location of	of Death		4c.	County of Death	
			Washington Adve					a Parl	-		Mo	ontgomer	У
	Funeral Director		229-03-7627	6. Sex 7. Ag	e (In yrs. la 84	st birthday) Yrs.	Months Days		A diam	8. Date of Birt (Month, Da Feb 5	Year)	9. Birth Cou Virg	place (State or Foreign ntry) Inia
	pu &		Usual Residence of Decedent  10a. State 10b. County		10c. City	Town or Lo	cation						10d. Inside City Limits
	Aaryla sho	ō											1 XYes 2 No
	28e-1	ect	Maryland Montgo	omery	lak	coma P	10f. Zip Code				10a. Citiz	en of What Cou	ntry?
	with	直	7804 Cole Avenu	10			2091	2			•	S.A.	,.
	leath ns 23	Funeral Director	11. Marital Status	12. Was Decedent		S. 13. <sup>1</sup>	Was Decedent of If Yes, specify Cu		gin? (Spe	cify Yes or No		4. Race - Ameri	can Indian,
က	or Iter	Fur	1 ☐ Never Married 2 🔀 Marri	Armed Forces?		j			n, Puerto i	Rican, etc.)		Black, White	etc.
ğ	rai', o	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2 🛣 No	Specify:				Specify: Wh	ite
21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23a or 28e-f show evant, the Medical Examiner roust by notified at	Completed	15. Decedent' (Specify only highes	s Education t grade completed)		(Give	dent's Usual Occu	e durina mos	t of workir	ng	16b. Kir	nd of Business/Ir	ndustry
2	ithin an *	du	Elementary/Secondary (0-12)	College (1-4or 5		life.	DO NOT use retir	ed)			M - 1-	1	
2	filed w Hygier other tl		47 Fatharda Nama (First Middle I	1		Maint	enance F			(First, Middle,	Medi		
anc	ould be fi Mental H arked ot atic evar	Be	17. Father's Name (First, Middle, L Burnett R. Jenl							ae Goo			
Ž	2 should be filed within and Mental Hygiene. Is marked other than aumatic evant, Ire M	2	19a. Informant's Name/Relationsh			19h Mailir	ng Address (Stree						Code)
Maryland	d 2 s th an 27 is trau		Mike Jenkins	[][N] ]			Cole Ave						
	Heal Heal tem 3		20a. Method of Disposition				sition (Name of matory or other pl	-	D	ate	_	cation - City or T	own, State
<u>o</u>	ages ant of it: if i		1 X Burial 2 ☐ Cremation  1 4 ☐ Donation 5 ☐ Other (Sp				natory or other pi Chapel C		3/21	/05 I	urav	, Virgi	nia
Baltimore,	orter injur		21. Signature of Funeral Service t				2. Name and Add	ress of Facilit	ty				
ñ	permit. Pages 1 and 2 should be Department of Health and Menta Importent: if item 27 is marked any injury or other traumatic es		The Bradley Funeral Home, Inc. 187 E. Main St., Luray, VA 22835										- 1
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused	d the death.	. Do not ent							Approximate Interval Between
	Pnysician :		Immediate Cause (Final disease or condition	My	Oca	Wille	all m	Dane	Y	1071			Onset and Death
	/Medical		resulting in death)	Due to (or as	a consequ	ence of):	10.	2000		wy			1 any
п	Examiner		Sequentially list conditions.	b									105/4
7	P #	Iner	Sequentially list conditions, in any, reading to immediate cause. Enter Underlying	Dise to (or as	& DURSECIA	anga uf):							
	ecute and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a conseque	ence of):							
8760,	ate be executed hysicien and the burial-transit	cal E			a 551.5545	0.100 0.7.							
687	death certificate be executed e ettending physicien and rd for use as the burial-transit	edic		d									
Box (	leath certifica ettending ph I for use as tl	Z/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							2	3d. Date of deliv	ery
ă	death e ette d for	Iclai	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant a			⊒Ectopic pregnan ] Other (s <i>pecify</i> ) ,	cy				Month	Day Year
0	that the de ed by the detached	Physician/M	9 ☐ Unknown	9□ Unknown									
Б,	res tha igned I be det	by P	Part II. Other significant condition	ns contributing to death b	out not resul	lting in the u	nderlying cause g	oven in Part I		23e. Did to	bacco u	se contribute to	he cause of death?
ord	w require been sig should b	ed	Alberton	rum	1	0.0				10	′es 2[	No 3□Pro	bably 4 Unknown
Records,	8 5 6	ompleted	Coronary	antery	NV	Dell	21			24a. Was	SV	prior to co	opsy findings available ompletion of cause of
m —		Соп	, (							perfo	rmed2 2LZ No	death?	2 No
Vital	Physician: Th this certificate ral director, pag	Be (	25. Was case referred to medical examiner?						of Death	(Check only o	ne)		
of \	Physical this call direction	ပို	1 ☐ Yes 2 No	Hospital: 1 Xinpatio		R/Outpatier	IT 3L DOA	-				Other (Speci	fy)
		on:	27. Manner of Death  1 Natural 5 ☐ Pendin		y Year)	28b. Time o Injury	W	uryat ork? ⊒Yes 2 🔲		28d. Describe I	iow injury	occurred	
isio	or at	icat	2 Accident investig	not be an Place of In	iumz - At hor	mo form st	M 1 [			Rf Location /	Street and	Number or Ru	al Route Number.
Division	or Attencater death Diractor:	Certification;	4 ☐ Homicide determ	building, ei	tc. (Specify,	)	eet, ractory, once	ð	'	City or Tov		Transpor or tran	ai i iodio ivanibor,
_	To the Hospital or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune		29a. Certifier 1 ☑ Certifyin	g Physician: To the best	of my know	vledge, deat	h occurred at the	time, date an	nd place. a	and due to the	cause(s)	and manner as	stated.
	P Full	Medical		Examiner: On the basis of and manner st	of examinati								
	To the within 2 To the complet	Me	29b. Signature and title of certifier	0000			29c. Licer	nse number	0	,	29d. Date	signed (Month	Day, Year)
}	A		• (HUDING	LLAN	1		D	503	58/		6	31181	OS
	P		30. Name and address of person	who completed cause of	death (Item	23а) (Туре,	Print)	/	20.1		0 -	A	1 1 -
_	U		KOBYN D	HNDER	80	NZ	600 Ca	well	VOH	e va	EOM	la far	(LAU) 2021
	Sta		31. Date filed (Month, Day, Year)	29	rar's Signat	ure	W						
	Registi	ar	MAR 2 5 20	UJ COCKER	100	7							

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) Month Day Vaar **Physician** 6:33 AM 22 2005 Willie Jackson March /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Sinai Hospital of Baltimore If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country)
 NC 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) 1**∑**M 2□ F Director 212-18-0764 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County other traumatic event. If a Medical Examinar pust be notified at XXYes 2 No Completed by Funeral Director Baltimore NA MD 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? U . S . A .

14. Race - American Indian,
Black, White, etc. items 23a 1510 Mosher Street 21217 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No It Yes, Give 1 Never Married 2 Married ŏ 1 ☐ Yes 2 No Specify: Specify: **Widowed 4** □ Divorced If Yes, Give Year or Dates: Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within 7 Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) is marked other than Engineer Union Local 194 6th grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be f lealth and Mental I Henry Jackson ပ Margie Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 I Sylvia Johnson-Niece 2401 Elsinore Ave, Baltimore, Md. 21216 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages nent of h Department of Important: If it any injury or o once. 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Garrison Forest Vet. 3/28/05 Owings Mills, Md 21. Signature of Funcion Service Licensee 22. Name and Address of Facility
March F/H West 21215 elle Ames 4300 Wabash Ave, Baltimore, Md 23a. Part 1. Ent. the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sepsis **Physician** days /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 2 No 1 Yes Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by after 4 Homicide within 24 hours a To the Funeral L 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier RES-000 March, 22, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospital of Baltimore Bashandy, MD Sinai

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/200

State Registrar 31. Date filed (Month, Day, Year)

MAR 2 5 2005

ORIGINA

32. Registrar's Signature

			State of Maryland / De			-		1 0 1 0 0
		•	- FOI	ertificate of D		Reg. N	4000	10182
	Dhusisi		Decedent's Name (First, Middle, Last)			ate of Death	ay Year	3. Time of Death
	Physicia /Medic		Albert Alton Jasper, Jr.				3 2005	03:53 4
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or L	_ocation of Death		c. County of Death	1
	Funeral		8355 Peachwood Drive 5. Social Security Number 6. Sex 7. Age (In yrs. last birtho		If Under 24 Hrs. 8. Da	ato of Ridh	Howard 9. Birth	place (State or Foreign
	Director		577-36-3464 1\(\frac{1}{X}\)M 2\(\Delta\)F 76 Yr	Months Days	Hours Min. JUN	fonth, Day, Yea IE 27, 1	.928 Wasi	nington, DC
	pu ≱		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town of	r Location				10d. Inside City Limits
	faryla r shov	ō						1 ☐ Yes 21 No
	the N	Director	MD Howard Jessup  10e. Street and Number	10f. Zip Code		10g. C	Citizen of What Cou	untry?
	h with	ai Di	8355 Peachwood Drive	20794				
	ams ams	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of His If Yes, specify Cuban,	panic Origin? (Specify Y , Mexican, Puerto Rican	res or No-	14. Race - Amer Black, White	
36	s afte	by Fu	1 □ Never Married 2 □ Married 1 □ Wes 2 □ No 11 Ves. Sive Year or Dates: 1946-48		Specify:		Specify: whi	te
8	72 hours after death with the Maryland natural', or Itams 23a or 28a-f show digal Examinat frontified at		15 Decedent's Education 16a. D	ecedent's Usual Occupati	tion	16b.	Kind of Business/l	ndustry
215	within 72 ene. than "ne	piet	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0·12)  College (1-4or 5+)	ive kind of work done du e. DO NOT use retired)	uring most of working			
21	e filed within Il Hygiene. other then	Completed	12	Service I			Pepso	
nd	9 0 2 0	Be	17. Father's Name (First, Middle, Last)	1	18. Mother's Name (Firs Muriel Pet		en Sumame)	
3	should I a marke umatic	၉	Albert Alton Jasper, Sr.  19a. Informant's Name/Relationship (Type, Print)  19b. Name/Relationship (Type, Print)	ailing Address (Street an			or Town State 7	in Code)
Maryland 21215-0036	s 1 and 2 should f Health and Mer tam 27 is marke other traumatic			Peachwood		-	20794	p 0000)
ē,	s 1 ar f Hea itam itam other		20a. Method of Disposition 20b. Place of D	isposition (Name of crematory or other place)	Date	20c.	Location - City or T	own, State
Ë	Pages nent of I nnt: If its ury or o		1 Deuriai 2 i Yoremation 3 Differnoval from State	eake Crem. I		05 Be	eltsville	e, MD
Baltimore,	permit. Pages Department of I Important: If its any injury or of		21. Signature of Funeral Service License	of Facility Man Funeral	l Home @	Meadowri	dge MP, Inc.	
			23a. Part 1. Enter the disease, or complications that caused the death. Do not	7250 Washing enter the mode of dying,	such as cardiac or resp	ELKY100 piratory arrest,	ge, MD /	1075 Approximate Interval Between
N	Pnysician		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition as Cause of the Cause (Final disease or condition as Cause of the Caus	ant Call	50			Onset and Death
	/Medical		Due to / as a consequence of					10(1)
п	Examiner	L	Sequentially list conditions, if any leading to immediate Due to (or as a consequence of)	te Cardio	Vascular	diser.	re	YCKIS
	ted sit	nine	cause. Enter Undertying Cause (Disease or injury	11-16				112 -10
,	te be executed ysician and le burial-transit	Examiner	that initiated events resulting in death) Last c. Due to (or as a consequence of)	arcio				years
760,	ysicia ysicia	call	d					
68	leath certificate t rattending physic I for use as the b	Medi	IF FEMALE:					
Вох	ath ce ttendi or use	Physician/Med	23b. Was decedent pregnant  1 Live birth 2 Fetal death	3 Ectopic pregnancy			23d. Date of deliver Month	very Day Year
0	at the de by the a tached f	ysic	1 Yes 2 No 4 Pregnant at time of death 9 Unknown	5 Other (specify)				
Δ.	The law requires that the death certifical ate has been signed by the attending phy bage 2 should be detached for use as the		Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause giver	n in Part I. 2	23a. Did tobacco	use contribute to	the cause of death?
rds	w requires been sign should be	ed by				1 🗋 Yes	2□No 3□Pro	bably 4 Dunknown
Records,	e law re has bee je 2 sho	Completed			2	24a. Was an autopsy	24b. Were aut	opsy findings available ompletion of cause of
Ä		Com			1	performed? ☐ Yes 2 ☐ 1	death?	200
Vital	ician: Th certificate rector, pag	Be	25. Was case referred to medical exampler?  Hospital:	Other	26. Place of Death (Che			
of	hys this at dir	. To	1	atient 3 DOA	4   Nursing Home :	5 Presidence Describe how in		ify)
ion	ding th. : Afte	ition	1 Inlatural 5 ☐ Pending (Month, Day Year) Inju	ry Work?	? es 2 □ No			
Division	r Atter	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, tarm building, etc. (Specify)	, street, factory, office		ocation (Street	and Number or Rui	ral Route Number,
Ö	itaio Irsaft raiDi							
	To the Hospital or Attending Physician: within 24 hours after death.  To tha Funaral Diractor: After this certific completely filled in by the funeral director.	Medical	29a. Certifier (Check only one)  1 Criffying Physician: To the best of my knowledge, or the basis of examination and/one and manner stated.					
	To the To the Comp	Me	296. Signature and title of certifier Deput	29c. License		29d. C	Date signed (Month	. Day, Year)
)	AVI		1 Anatyens ME	D3	1473 WayEll	W	ar 18.2	2005
	14,		30. Name and address of person who completed cause of death (Item 23a) (To	rpe, Print)	. 1. []	1 H	+ 44.0	21042
	Sta	ate	31. Date filed (Month, Day, Year)  31. Date filed (Month, Day, Year)  32. Registrar's Signature	Code Cone	wayen	1 (3)11 (1	y my	21072
	Regist		MAR 2 5 2005					

			State of Maryland / Department State of Maryland / Certification		lental Hyg	•	10183
	Physici /Medio	al	1. Decedent's Name (First, Middle, Last) Owen David Larkins	Town, or Location of Death	2. Date of Deat Month		3. Time of Death 6:15 P.M
	Examin Funeral Director	er	Garden View Health Center Bal	r 1 Year   If Under 24 Hrs.   Days   Hours   Min.	8. Date of Birth (Month, Day,	N/A  9. Birth Cou	place (State or Foreign intry) aryland
	D	tor	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  Maryland N/A Baltimore		000. 2.		10d. Inside City Limits  ↓√Yes 2 □ No
	th with the 23a or 28a	Funeral Director	912 N. Carrollton Avenue	21217	1	0g. Citizen of What Cou USA	intry?
920	be filed within 72 hours after death with the Maryland hat Hygiene. Id other then "neturel", or flome 23e or 28e-f show avent, I're Medicel Expringer most be notified at		11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes 2 No If Yes 2 No Year or Dates:	dent of Hispanic Origin? (Spicify Cuban, Mexican, Puerto 20 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Black Specify:	, etc.
1215-0	within 72 ho iene. than "natur I'e Medical	Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  10th grade  16a. Decedent's Us. (Give kind of w. life. DO NOT to	al Occupation ork done during most of work ise retired)		16b. Kind of Business/Ir Private II	
Maryland 21215-0036	ould be filed Mental Hygistrkad othar artic avant, I	To Be Co	17. Father's Name (First, Middle, Last) Chester James Larkins	18. Mother's Name	e (First, Middle, M		idusery
	1 and 2 sho Health and I am 27 is mu thar traums		Constance Harmon/ Sister 425 W. 1	s (Street and Number or Rura Market St.	Snow Hi		land21863
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If itam 27 is marked any injury or other traumatic as once.		1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  1 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Paneral Service Licensee  22. Name a	Vet. Cem. 2	3/05 (	Crownsvill -Harris Fu	le,Marylan unerl Home
	Physician	-	23a. Part1 Enter the disease, or complications that caused the death. Do not enter the most shock, or head failure. List only one cause on each line.  Immediate Cause (Final disease or condition  a. Multiple of the condition of	altimore, M	Approximate Interval Between Onset and Death		
68760,	Medical Examiner  bhysician and sthe burial-transit	dical Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  C.  Due to (or as a consequence of):  d.				
P.O. Box (	es that the death certifica igned by the attending ph be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \[ \text{Yes} \] 2 \[ \text{No} \] No 9 \[ \text{Unknown} \] Unknown			23d. Date of deliv Month	ery Day Year
	The law requires that the ate has been signed by the bage 2 should be detache	by	Part II. Other significant conditions contributing to death but not resulting in the underlying	cause given in Part I.		pacco use contribute to t	
tal Rec		e Completed	25. Was case referred to medical	26. Place of Death		y prior to co death? 2 □ No 1 □ Yes	opsy findings available impletion of cause of
Division of Vital Records,	ng Phy fter this ineral d	atlon: To B	examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 EP/Outpatient 3 D	OA Other: 4 Nursing Ho	me 5□Reside	nce 6 □Other (Speci ow injury occurred	fy)
Divis	pital or Atta burs after de aral Diracto	l Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factor building, etc. (Specify)		City or Town		
<b>L</b>	To the Hospital or Attandi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred and manner stated.  2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	n, in my opinion, death occurr	ed at the time, da	ate and place, and due t	O the cause(s)
	3		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  A HMED MD 821 N Eula	D3912) m ST Bal	timore	MD 2120	
	Sta Registr		31. Date filed (Month, Day, Year)  MAR 2 5 2005	-			·

			1 - For Amend Item#	State 19a.per	of M	arylan G842	d / Depa , 4 / 20 / <i>Cer</i>	rtment tificate	of H	ealth a	and M	iental Hy	giene Reg. No.	05	10184
	<b>.</b>		1. Decedent's Name (First, Midd	le, Last)								2. Date of De		Voor	3. Time of Death
	Physici /Medio		Cecil				Lee					March	19, 200	)5'**	8:45 AM
	Examir		4a. Facility Name (If not institution		number)			4b. City, To		_	of Death		4c. Count	y of Death	
			Suburban Hosp					Beh			0411			gome	
	Funeral		5. Social Security Number	6. Sex 1 2 M 2 □	7. Ag F	10 (In yrs. 1 65	ast birthday) Yrs.	If Under 1 Months	Days	If Under Hours	Min.	8. Date of Bir (Month, Da July 20	th ly, Year) 1939	Cou	place (State or Foreign ntry)
	Director		226-48-4459 Usual Residence of Decedent								L	July 20	7, 1939	Virg	gínia
	yland		10a. State 10b. County	′		10c. City	, Town or Lo	cation							10d. Inside City Limits
	Mar.	to	Maryland Mont	gomery		Вє	thesda	l							1 ☐ Yes 2 🔯 No
	th the	ire	10e. Street and Number			-		10f. Zip C	ode				10g. Citizen of	What Cou	ntry?
	23a	ai	5721 Grosvenor	Lane					208	14			U.S.A.		
	ar dez	by Funeral Director	11. Marital Status	Ame	Forces?		S. 13. V	Vas Deceder Yes, specify	nt of Hi y Cuba	spanic Ori n, Mexicar	igin? (Spe 1, Puerto	ecify Yes or No Rican, etc.)		ce - Ameri	ean Indian, etc.
36	s afte	, F	1 XNever Married 2 Mai 3 Widowed 4 Divorce	If Yes	es 2.∭∑(i ,Give orDates:	No	1	☐ Yes 2页	X No	Specify:			Speci	fy: D.1	- 1
Ç	hour	edt		nt's Education	Dates.		16a Deced	lent's Usual (	Occupa	ation			16b. Kind of E		ack
5	nin 72 n ne	piet	(Specify only highe	st grade complet		E . \	(Give life. L	kind of work OO NOT use	done d	<i>furing</i> mos	t of worki	ing			330117
213	d with	Completed	Elementary/Secondary (0-12)	Collec	je (1-4or :	5+)	Custo	dian					D.C. Pu	ıblic	Schools
b	e file al Hys I othe vant,	Bec	17. Father's Name (First, Middle	Last)						18. Mothe	er's Name	(First, Middle	, Maiden Suma	me)	
<u></u>	Menta	5	Unobtainable							Alv	enia	Lee			
2	parmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deparmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Innortant: if time 27 is marked other than "natural", or Itams 23s or 28s-f show any injury or other traumatic evant, the Medical Exacting for mantice and once.		19a. Informant's Name/Relation		DIE	ster)		-					er, City or Town		
2	and ealth m 27 her tr		Lucy Marie La	whorn	( <del>Dau</del> g	shter				St.,			ton, DC		
ore	ges 1 tof H if ital		20a. Method of Disposition 1  Burial 2  □ Cremation	3 □Removal fr	om State	20b. P	lace of Disposements Chenezi Church	sition (Name natory or othe e.r. Ba	of er place	st i		Date	20c. Location	- City or To	own, State
Ë	tmen tant: jury	L	`4 □ Donation 5 □ Other (	Specify)		Ì					3/26,	/05	Supply	, VA	
<u></u>	Sarmil Separ mpor mpor nny in		21. Sign (ure o Funeral Service	Licensee	4_	_	22	Name and Cedel	Br	ooks	Fune	ral Hon	ne		
	40240	_	23a. Part1. Enter the disease, of	_ O'LOV	me	un doath	Do not onto						VA 225	535	Approximate
			shock, or heart failure. Lis	t only one cause	on each li	ne.	i. Do not ente	ar the mode (	or dynng	y, such as	cardiac	i respiratory a	11651,		Interval Between Onset and Death
	Pnysician /Medical	î j	disease or condition resulting in death)				Fibril	latio	n					- 4	
	Examiner					a consequ	ience of):								
		er	Sequentially list conditions, if any, leading to immediate	b. Dem	to (or as	a consequ	uence of):								
- 8	cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events	. Hyp	erte	nsior	1								
20	The law requires that the death certificate be executed that been signed by the attending physician and bage 2 should be detached for use as the burial-trans	Ex	resulting in death) Last	Due	to (or as	a consequ	ence of):								
2876	ate be nysicii he bu	dicail		d											
7	certifica inding pt use as t	Med	IF FEMALE:												
30	eath certifi attending I for use as	by Physician/Me	23b. Was decedent pregnant in the past 12 months?		ve birth	2 Fetal	death 3	Ectopic preg						ite of delive	ery Day Year
1	the a	sic	1 Yes 2 No		egnant at nknown	t time of de	eath 5	Other (spec	cify)				100	Sintin	Day Toal
$\sim$ $\sim$	that the dead by the detached	Ph)	Part II. Other significant conditi	ons contribution	n death h	ut not resu	ulting in the un	iderhing eau	ico anyo	n in Part I		23e Did to	obacco use con	tribute to t	ne cause of death?
	ires tha signed d be de	1 by	,	arra continuating			ining in the di	idonying odd	150 giva	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	•				ably 4 Unknown
70	w requir been s should	Completed													
2 de	has has	mpl										24a. Was autop perio	an 24b. osy ormed?	prior to co death?	psy findings available mpletion of cause of
- ) =			OF Man and referred to madic										2 🔼 No	1 ☐ Yes	2 No
Į, į, į, į, į, į, į, į, į, į, į, į, į, į,		o Be	25. Was case referred to medical examiner?	Hagnital	☐ Inpatie		ER/Outpatient	3 □ DOA	Othe			(Check only o			
0) 6	Phys or this oral di	: To	27. Manner of Death		ate of Inju Month, Da		28b. Time of		. Injury	at	-		dence 6 🗆 Oth		y)
0 0	Attending I r death. actor: After by the funer	atio	1 X Natural 5 ☐ Pendi 2 ☐ Accident invest	ng (^ igation	nonth, Da	y Year)	Injury	М	Work	.? ∕es 2 🔲 l	No				
	or Attence after death Diractor:	ifice	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ningd   286. P	ace of Inj	ury - At ho	me, farm, stre	et, factory, o	office		2	28f. Location (S City or Tox	Street and Numi	ber or Rura	l Route Number,
	spital or Al ours after aral Dirac filled in by	Certification:	4 LI Homoldo	, o	anding, et	o. (Spaciny	,					City of You	vii, Sialej		
Pecil Le	Hospital 24 hours a Funaral I		29a. Certifier 1 Certifyi (Check only 2 Medical	ng Physician: To Examiner: On the	the best	of my know	wledge, death	occurred at	the tim	e, date an	d place, a	and due to the	cause(s) and m	anner as s	tated.
()	를 들 <b>을</b> 들	Medical	one)	and r	nanneret	ated.		-			5000111				
	With To	2	29b. Signature and title of certific		//	l V	$\Lambda$	29c. L		number			29d. Date signe		
	i		~	/ h	~		00 /		HO	05128	0		March	Z1,	2005
	\		30. Name and address of person			leath (Item			11 f i i	170 Da	rk T	orr (	Germanto	מעט	MD
	Sta	to.	Anushiravan D  31. Date filed (Month, Pay, Year			ar's Signa			uLI	ve la	rrv I	و و عدد		W 11 9	.14
	Registr		31. Date filed (Month, Pay, Year MAR 2, 5	2005		1. 15.	Loc	de la							

	,	1 - For Amend Item 2	per Dr.,G84	2,03/0	Afficate of	Death	100:	Reg. No	), ), ), (21 /05	3. Time of Death
Physicia	an	Decedent's Name (First, Middle, Last)  T. T. T. T. T. T. T. T. T. T. T. T. T. T					- 36	1 2 -	3/21/05 2005	
/Medic	al	James Lee  4e. Facility Name (If not institution, give st	reet and number)		4b. City, Town, o	r Location	of Death		County of Deet	5:30 AM <sup>M</sup>
Examin	er	Collingswood Nurs			Rockvi1				Montgome	
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs	last birthday)	ff Under 1 Year Months Days	If Under Hours		of Birth	9. Birt	thplace (Stete or Foreign ountry)
irector		3/1-24-4/26	M 2□F 79	Yrs.	Working Cays	110013	June	e 14, 1	925 M	ichigan
-	}	Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Lo	ocation					10d. Inside City Limits
the Mudical Exerciper must be notified at	to	MD Montgome	ery	Potoma	.c					1 ☐ Yes 2 🔀 No
	Director	10e. Street and Number			10f. Zip Code			10g. Ci	itizen of What Co	ountry?
		8037 Inverness Ric	lge Road			20854			USA	
	Funeral	11. Wantar Charac	<ol><li>Was Decedent Ever in I Amned Forces?</li></ol>	J.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Or an, Mexica	rigin? (Specify Yes in, Puerto Rican, e	or No-	14. Race - Ame Black, Whit	
	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 4.	3-46	1⊡Yes 2⊠No	Specify:	:		Specify: 2	asian
		15. Decedent's Educ	ation	16a. Dece	dent's Usual Occup	ation	-4 -4	16b. h	(ind of Business/	/Industry unk
	ple	(Specify only highest grade Elementary/Secondary (0-12)	Coffege (1-4ot 5+)	lite.	kind of work done DO NOT use retired	during mos	st of working			
	Completed	12	4	pr	ogram man				0	
	Be	17. Father's Name (First, Middle, Last)				18. MOTH	er's Name (First,			
	2	Loy Hong Lee  19a. Informant's Name/Relationship (Type	e Print)	19b. Maili	ng Address (Street	and Numb	Shee Le			Zip Code)
		Helen B. Lee/spou			Invernes					20854
		20a. Method of Disposition		Place of Dispo	osition (Name of matory or other place	ce)	Date	20c. L	ocation - City or	Town, State
		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re  '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	•		1				
NIIVE.		21. Sgrature Funeral Ser Ice License RONAT I Ce License	ade, Directo	E 5	Name and Addre tate Anat altimore,	omy E	Board 655 21201	W. Ba	ltimore	Street
		23a. Pan1. Enter the disease, or complice shock, or heart failure. List only on	ations that caused the dea				s cardiac or respira	atory arrest,		Approximate Interval Between
	N 4	Immediate Cause (Final disease or condition	7 1	dheel	2					Onset and Death
		resulting in death)	Due to (or as a conse							
	٠.	Sequentially list conditions, b.	Due to (or as a conse	ween						
1	nlne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to the as a conse	querice ory.						
	Examine	that initiated events c. resulting in death) Last	Due to (or as a conse	quence of):						
	cal	d								
	Med	IF FEMALE:	Bc. If yes, outcome of preg							
	Physician/Med	in the past 12 months?	1 Live birth 2 ☐ Fe 4 ☐ Pregnant at time of	tel death 3[	☐Ectopic pregnanc	y		- 3	23d. Date of de Month	Day Year
	yslc	1 □ Yes 2 □ No 9 □ Unknown	9□Unknown	oguii o						
	by Pt	Part II. Other significant conditions con	tributing to death but not re	sulting in the u	inderlying cause giv	en in Part	1. 236	e. Did tobacco	use contribute to	o the cause of death?
								1 ☐ Yes 2	2 DNo 3□PI	robably 4 Unknown
	Completed						248	a. Was an autopsy	24b. Were au	utopsy findings available completion of cause of
	Com						1□	performed? Yes 20.N	death?	\_/
	Be (	25. Was case referred to medical examiner?				/	e of Death (Check			
	10 1	1 ☐ Yes 2 No	ospital: 1 ☐ Inpatient 2 [ 28a. Date of Injury	28b. Time of	nt 3 DOA		tursing Home 5[	☐ Residence scribe how inju		ocify)
	tlon	1 Natural 5 Pending	(Month, Day Year)	Injury	Wo	rk? Yes 2 🗆		001100 11010 11111	31,9 00001100	
	Certification;	3 Suicide 6 Could not be	28e. Place of Injury - At		reet, factory, office					ural Route Number,
	Certi	4 Homicide	building, etc. (Spec	erry)			Chy	or Town, Stai	(0)	
		(Check only 2 Medical Examin	ician: To the best of my ki							
	Medical	one) 29b. Signature and title of certifier	and manner stated.		29c. Licens				ate signed (Ment	
		Destained Ton	iske Ma	4, 716	D	519	16	M	arch	21,2005
		30 Name and address of person who co	moleted cause of death (Its	em 23a) (Type	Print):	<i>\( \)</i>		<u> </u>		21, 2005 le, MD 2085
		Patricia lows	O Nau I	HIM D	ockville	Pi	Ke, G-,	100, R	ockvill	le, MV 2085
Sta	ite	31. Date filed (Month, Day, Year)	32. Registrat's Sig					/		-
gistr	ar	MAR 2.5 2005	A A	1 Acres	13º 10					

DHMH 17 Rev 1/2001

			For	State of Marylan			Mental Hy	giene	10105
			- State Registrar AMEND ITEM	20b PER FH G	841 <i>9425ipa</i>	te yr Death	2. Date of De	Reg. No U	0 10186
	Physici /Medic		1. Decedent's Name (First, Middle, Last)	1	wis		Marc	h 24, 200	25 / , 30/7.4
	Examin	er	4a. Facility Name (If not institution, give s 3007 Woods E	and Drive	2	OPPA		Harto	rd Co.
	Funeral Director		5. Social Security Number 6. Sex 218-52-1625	A /	Yrs. Months	or 1 Year   If Under 24 Hrs.   Days   Hours   Min.	8. Date of Bi	8 1949 M	irthplace (State or Foreign Country)
	Maryland e-f show	ctor	10a. State 10b. County Maryland Harto	ord Co. 10c. cit	y, Town or Location Toppa				10d. Inside City Limits 1 ☐ Yes ATNo
	th with the 23a or 28 set be no	al Director	3007 Woods	End Dri	ve 101. z	21085		10g. Citizen of What	Country?
936	hours after death with the Maryland tural', or Items 23a or 28e-1 show al Examiner outt be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 201 No If Yes, Give Year or Dates:	.S. 13. Was Dec If Yes, sp	edent of Hispanic Origin? (Secrify Cuban, Mexican, Puerl	pecify Yes or No o Rican, etc.)	14. Race - Al Black, W Specify: (	merican Indian, hite, etc. ////
21215-0036	within 72 ane. than "na	Completed	15. Decedent's Educ (Specify only highest grade			ual Occupation ork done during most of work ase retired)	king	Auto Pa	ss/Industry
Maryland 2	be filed tal Hyg d othe event,	To Be Co	17. Father's Name (First, Middle, Last)  Carmin A	Trupia	001	1.45	ne (First, Middle	Maiden Sumame)  K. Roll	,
Mary	12 sh h and 7 Is m traum		19a. Informant's Name/Relationship (Type)	oe, Print) HUS.	3007 W	ss (Street and Number of Ru	Prai Route Numb	per, City or Town, State	MD, 21085
nore,	of H of H Miter		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ R	20b. F	Place of Disposition (Notemetery, cramatory or	ame of other place) 3/28	72005	20c. Location - City	or Town, State
Baltimore	permit. Pag Department Importent: any injury o		21. Signature of Funeral Service License	gan k	22. Name of Peach	and Addr s of Facility	afives,	Funeral+	Semation Ctr.
	Pnysician		23a. Part. Enterthe disease, or complications, or heart failule. List only on Immediate Cause (Final	(1)		ode of dying, such as cardiac	or respiratory a	arrest,	Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	Due to (or as a conseq	uence of):				Gyers
	rted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence of):				
8760,	cate be executed physician and the burial-transit	dicai Exa	that initiated events resulting in death) Last	Due to (or as a conseq	uence of):				
.O. Box 68	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ★ 0 9 □ Unknown	3c. If yes, outcome of pregns 1 □Live birth 2 □Feta 4 □ Pregnant at time of d 9 □ Unknown	Il death 3 □Ectopic			23d. Date of o	delivery Day Year
<u>α</u>	uires that t signed by Id be detac	by	Part II. Other significant conditions con	ntributing to death but not res	ulting in the underlying	cause given in Part I.			to the cause of death?
of Vital Records,	0 - 0	Completed						s an 24b. Were prior to death 2 No 1 Y	autopsy findings available o completion of cause of
ital	icien: Th certificate ector, pag	BeC	25. Was case referred to medical examiner?			26. Place of Dea	1 ☐ Yes		95 21,7110
on of V	Phys this rat dir	P	1 Yes 2 Ko	lospital: 1 Inpatient 2 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatient 3 0 0	OOA Other: 4 Nursing F 28c. Injury at Work? 1 Yes 2 No		idence 6 Other (Since the control of	pecify)
Division	or Attending P after death. I Director: After t d in by the funera	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Specif			28f. Location ( City or To	(Street and Number or wn, State)	Rural Route Number,
	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune	edical C	29a. Certifier Certifying Physical (Check only one)	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, death occurre	d at the time, date and place on, in my opinion, death occu	, and due to the irred at the time,	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier		2	9c. License number		29d. Date signed (Mo	
)	\ _		mely	カラ		038409		3/24/	- 1
	V		30. Name and address of person who co	impleted cause of death (Iter	m 23a) (Type, Print)	115, Litreril	le ha	71063	
• •	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	171,0 1110011		(10)	
	Registi	ar	MAR 2 5 2005	Heren S.	15				

			1- For State Registrar	ate of Maryla			of Health of Death			jiene() () (	5 10187			
	Physici	an	Decedent's Name (First, Middle, Last)	Tomas mi				2	. Date of Dea Month		3. Time of Death			
	/Medi			<del></del>	nomas L				3	20 200	)5 1:45 am			
	Examir	er.	4a. Facility Name (If not institution, give street			4b. City, To	wn, or Location			4c. County o	f Death			
			5 Dunhaven Place Ap 5. Social Security Number 6. Sex		s. last birthday)	Peri If Under 1			Date of Birth	Balto				
н	Funeral Director		241-42-0002 1XM				ays Hours	Min.	Date of Birth (Month, Day 4-21	-1932	9. Birthplace (State or Foreign Country) N.C.			
	p		Usual Residence of Decedent											
	ahow d at	_	10a. State 10b. County		City, Town or Lo						10d. Inside City Limits			
	Ba-1 s	cto	Md Balto	I	Perry Ha	all					1 □ Yes 2√ No			
	vith th	Dire	10e. Street and Number			10f. Zip Co	ode		1	0g. Citizen of Wh				
	s 23	eral	5 Dunhaven Place			212				USA				
	ter de	Funeral Director	A	as Decedent Ever in med Forces?	0.5.	f Yes, specify	t of Hispanic Ori Cuban, Mexicar	n, Puerto Ric	oan, etc.)		- American Indian, , White, etc.			
036	72 hours after death with the Maryland natural', or Items 23a or 28a-1 show disal Evar, if writhust be rediffed at	þ	3 ☐ Widowed 4 ☑ Divorced Y	□Yes 2 XNo Yes, Give ear or Dates:		1 ☐ Yes 2 🔀	No Specify:			Specify:	Black			
2-0	72 ho	ted	15. Decedent's Education (Specify only highest grade com	nleted)	16a. Dece	dent's Usual C	occupation	et of working		16b. Kind of Bus	iness/Industry			
21215-0036	ithin "le.	Completed	Elementary/Secondary (0-12) C	ollege (1-4or 5+)	1		done during mos retired)	N OF WORKING		Box Mar	nufacturer			
	iled w tygiei her ti		6th grade  17. Father's Name (First, Middle, Last)	N/A	P	ress Op	perator	- d- N //	Fire A. Adiabatic	14.74				
Maryland	d be finital h	Be c	Otha Lucas				Cred	,	Anders	Maiden Sumame, On	)			
Z	shouth nd Me mark mati	2	19a. Informant's Name/Relationship (Type, P	rint)	19b. Mailir	na Address (S				Number, City or Town, State, Zip Code)				
	nd 2 alth at 27 is		Caryl Lucas - Daught	·			Avenue A				J. 07055			
re,	s 1 a of Hei Item		20a. Method of Disposition	20b.	Place of Dispo cemetery, cren	sition (Name	of	Date			ity or Town, State			
Ē	Page nent c		4 □ Donation 5 □ Other (Specify) Metro Crematory 3-23-20							Catonsvi	lle, Md			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants if Item 27 is marked other than "naturat", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Ever in at must be rediffed at ances.		21. Signature of Funeral Service Licensee	H West										
_	<u>205</u>		Terone a.		alto, Md 21215									
			23a. Part = Enter the disease, or complication shock, or heart failure. List only one cau	is that caused the dea		. 4 1 . 4	f dying, such as	cardiac or re	espiratory arr	est,	Approximate Interval Between Onset and Death			
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	HYPO	XE,	VIIF	<u> </u>				Onset and Dodain			
	Examiner			Due to (or as a conse	quence of):	VE +	1EAR	TF	ALL	2.50				
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	Due to (or as a conse	quence of):					100				
	cuted	Examiner	that initiated events	REN	AL	FAI	LUR	$\varepsilon$						
0,	e exe	I Ex	resulting in death) Last	Due to (or as a conse	quence of):									
8760,	The law requires that the death certificate be executed items been signed by the attending physician and bage 2 should be detached for use as the buriat-transit	dical	d											
9	eath certific attending p	/Me	IF FEMALE:	yes, outcome of pregr	2004									
Вох	atten for us	cian	in the past 12 months?	JLive birth 2 ☐ Fer ☐ Pregnant at time of	aldeath 3□	Ectopic pregr Other (specif				23d. Date Month	,			
0	that the de ed by the detached	Physician/Me		Unknown	304	2 Other (opecin								
٦,	res that iigned b	by P	Part II. Other significant conditions contribut	ing to death but not re	sulting in the ur	nderlying caus	e given in Part I		23e. Did tot	pacco use contrib	ute to the cause of death?			
Records,	w require been sig should b	ed t	DIABETES						1 □ Y€	s 2□No 3	☐ Probably 4 ∰Unknown			
ecc	e law re has be je 2 sho	piet	HYPERTENS	5 10 N					24a. Was a	n 24b. We	are autopsy findings available			
H		Completed							perform	ned? dea	or to completion of cause of ath?  Yes 2 No			
Vital	Physician: The this certificate al director, pag	Be	25. Was case referred to medical examiner?				_	of Death (C	Check only on	е)				
of	y s	2	1 XYes 2 No Hospita	1 inpatient 2						nce 6 Other				
no		ion:	1 XNatural 5 ☐ Pending	a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c.	Injury at Work? 1 Yes 2		I. Describe ho	w injury occurred	1			
Division	I or Attendi after death. Director: A I in by the fu	licat	2 Accident investigation 3 Suicide 6 Could not be	e. Place of Injury - At I	nome farm str				Location (St	reet and Number	or Rural Route Number,			
Div	al or / s after I Dire d in b	Certification;	4 Homicide determined	building, etc. (Spec	ify)	,,,			City or Town	, State)	or clarate realization,			
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer		29a. Certifier 1 Certifying Physician	: To the best of my kr	owledge, death	occurred at ti	he time, date an	d place, and	due to the ca	luse(s) and mann	ner as stated.			
	To the He within 24 To the Fu completel	Medicai	(Check only 2 Medical Examiner: Cone)	nd manner stated.	ation and/or inv			th occurred	at the time, da	ate and place, and	d due to the cause(s)			
	with To	2	29b. Signature and title of certifier	M an	1		cense number	62			Month, Day, Year)			
	<		///////////////////////////////////////		<u> </u>		/ <del>~~</del>	0 >		3/22	1005			
/	3		30. Name and address of person who complete	ed cause of death (Ite	m 23a) (Type,	Print) 9	)383 N. CHI	9PLE	ES 57	- 1	DWCDN			
	Sta	tę	31. Date file Month, Day Year)	32. Registrar's Sign			~ / i i				V 307			
	Registr	7.1	MAR 2.5 2005 January J. January											

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death <sup>Day</sup>2005 MARCH 22, **Physician** LAUFE 7:20 A MILDRED /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** MILFORD MANOR NURSING HOME BALTIMORE BALTIMORE If Under 1 Year | tf Under 24 Hrs. | Months Days Hours Min. B. Date of Birth Month Day, Year) JUN. 11, 1918 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** ALABAMA Director 213-14-3715 86 Yrs. Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene, 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthen "natural", or Itema 23a or 28e-f show the Medical Examiner must be nutified at 1 ☐ Yes 2 🔀 No Directo BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21208 4204 OLD MILFORD MILL ROAD USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No tf Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No þ Specify: WHITE 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other then Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental MITTENTHAL TILLIE WEINBERG SAMUEL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2::
Department of Health at
Importent; If item 27 Is
any injury or other trau MARK LAUFE / SON 229 LAZY HOLLOW DRIVE - GAITHERSBURG, MD 20878 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE HEBREW CEM. 3/24/05 REISTERSTOWN, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Pa.(1 Enter the disease, or or plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, or 1 art failure. List only one cause on each line. tmmediale Cause (Finat disease or condition resulting in death) **Physician** /Medical Due to (or as a conse **Examiner** Sequentially list conditions, if any, leading to immediate the property of the cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transit Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 🖪 No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 Yes 1 ☐ Yes 2 ☐ No 2 7 No 26. Place of Death (Check only one) 25. Was case referred to medical examiner' 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 🗌 Yes Certification: To 28b. Time of Injury completely filled in by the funeral 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred After t 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death 3 Suicide 6 Could not be 28e. Place of Intury - At home, farm, street, tactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funeral C 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) use of death (Item 23a) (Type, Print) allen 31. Date filed (Month, Day, Year) State MAR 2 5 2005 Registrar

DHMH 17 Rev 1/2001

			State of Maryland / Department of Health and Mental Hygiene 2000
			1- State Registrar Certificate of Death Reg. No.
1	Physic /Medi	cal	1. Decedent's Name (First, Middle, Last)  2. Date of Death Month Day Year O4:03 M  44. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death
	Examir	ier	Mercy Medical Centur Baltimore City
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 1 Under 24 Hrs. 8. Date of Birth Office (State or Foreign Months Days Hours Min. Office (State or Foreign GEORGIA) 9. Birthplace (State or Foreign GEORGIA)
	/land		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location         10d. Inside City Limits
	he Man 18a-t sh otified	ector	MD. N/A BALTIMORE 1X yes 2□No
	th with t	ai Dir	10e. Street and Number 3729 W. GARRISON AVENUE 10f. Zip Code 21215 10g. Citizen of What Country? U.S. OF A.
36	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-t show ite Medical Examinar must be notified at	by Funeral Director	11. Marital Status    12. Was Decedent Ever in U.S. Armed Forces?   1   Yes   2   No   No   No   No   No   No   No
1215-0(	d within 72 hou piene. r than "nature the Wedical E	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  16b. Kind of Business/Industry
Maryland 21215-0036	d 2 should be filed with th and Mental Hygiene. ?7 is marked other than traumatic event, the h	To Be Co	UNKNOWN UNKNOWN UNEMPLOYED  17. Father's Name (First, Middle, Last)  JAMES BIGGS  18. Mother's Name (First, Middle, Maiden Sumame)  GEORGIA MC BRIDE
Man	12 sho h and I 7 is me traume		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Baltimore, I	ges 1 an it of Heal It Item 2 or other		CHERYL NICHOLS (NIECE) 618 N. 32nd STREET APT.C PHILA. PA, 19104  20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place) METRO CREMATORY 3/25/05  CATONSVILLE, MD.
Balti	permit. Pa Departmen Important: any injury once.		21. Signature Funeral Service Licensee  22. Name and Address of Facility  LEWIS T. GWYNN FUNERAL HOME 21215-6393
	Fnysician /Medical Examiner		23a. Part 1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions  D.  Description:  Des
8760,	icate be executed physician and s the burial-transit	dicai Examiner	Sequentially list conditions, 2 any leading to immediate cause. Either Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Direct (ur as a consequence of):  c. Due to (or as a consequence of):  d
.O. Box 6	The law requires that the death certifics the has been signed by the attending pt page 2 should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown
ecords, P	w requires that been signed should be det	ted by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1   Yes 2   No 3   Probably 4   Dinknown
$\alpha$	in: The law r ificate has be or, page 2 sh	Completed by	Covariable discontinuous death?  Clause Vena discontinuous death?  24a. Was an autopsy performed?  1 yes 2 to 8  24b. Were autopsy findings available prior to completion of cause of death?  1 yes 2 to 8  25. Was case referred to medical
	nysicia iis cert directe	To Be	25. Was case referred to medical examiner?  1  Yes 2  No
Division of	To the Hospital or Attanding Physician: The law within 24 burus after death.  To the Funaral Director: After this certificate has completely filled in by the funeral director, page 2.	Certification; 1	27. Manner of Death 1 Anatural 5 Pending 2 Accident investigation 28a. Date of Injury 28b. Time of 28c. Injury at Work? 4 Injury 4 Work? 5 No 1 Year
<u>X</u>	tal or At s after d al Diract ed in by	Certifi	3 ☐ Suicide 4 ☐ Homicide  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospital or Attentwithin 24 hours after death To the Funaral Director: completely filled in by the	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	T vitt	2	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)
	(	1	30. Nam and address of pers in who completed cause if death (flem 23a) (Type, Print)
	1		Kovice, up year Hedical Center 301 St Brace, no 21202
	Sta Registr		MAR 2 5 2005  MAR 2 5 2005

Stanley Matthews Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. urpend item/23a,27,26a f. periff, 3241.3/31 (b) TI State of Maryland / Department of Health and Mental Hygiene 1 1 5 05-1998 1 - For State Registrar AKG Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician MATTHEWS Month Yeer STANLEY LEE 19 2005 March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A 2300 Round Road Baltimore Apt. Bl If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Min. Hours 38 5075 **№** M 2□F 64 217 Yrs. Director NOV.4,1940 MARYLAND Usual Residence of Decedent with the Maryland 10a. State 10b County 10c. City. Town or Location 10d. Inside City Limits 28e-f show the Medical Examiner must be notified at Yes 2□No BALTIMORE Director N/A MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 U.S. OF A. 21225 APT. B1 2300 ROUND ROAD items 23a Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after Specify: BLACK 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 🌠 No Specify: þ 3 ☐ Widowed 4 ₩ Divorced "netural" ieted 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) oe filed within 7. al Hyglene. Compi College (1-4or 5+)
UNKOWN Elementary/Secondary (0-12) UNEMPLOYED 12TH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 12 should be fi and Mental H Is marked of Be RUTH RICE YOUNG ALMOND MATTHEWS 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 820 S. CATON AVENUE BALTIMORE, MD. 21229 BELL (AUNT) DOROTHY 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages I Department of H Important: If Ite any injury or ot once. 1 ☐ Burial 2 Cremation 3 ☐ Removal from State METRO CREMATORY CATONSVILLE, MARYLAND 3/26/05 \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility LEWIS T. GWYNN FUNERAL HOME 21. Signature of Funeral Service @1215-6393 LEWIS GWYNN 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. PARK HEIGHTS AVENUE BALTO, MD. Approximate Interval Between Onset and Death Immediate Cause (Final Narcotic Intoxication (methadone and morphine) Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed physician and the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medicai as IF FEMALE nse s 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy The law requires that the death in the past 12 months? 1 ☐ Yes 2 ☐ No ţ Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 💆 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has page 2 cate ! of Vital certific To the Hospitel or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 SOther (Specify) at scene 1X Yes 2 ☐ No 2 3∏ DOA this 28c. Injury at Work? 27. Manner of Death 28a Date of Injury (Month, Day Year) 28d. Describe how injury occurred UK Time of Injury After Certification: Division 5 Pending investigation 1 Natural death. 1 ☐ Yes 2**X** No 3/19/2005 3:20 P 2 Accident **Director**: 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2300 Round Road Apt B 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by after 4 | Homicide scene Paltimore, MD within 24 hours a To the Funeral I 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cai (Check only one) and manner stated. 29b. Signature and tille of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) OCME March 20, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pernela E Southall, My 111 Penn Street Baltimore, Maryland 21201 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 5 2005 Registrar

				For State	State of M		partment of ertificate o	Health and N		60115	10101
				Registrar  1. Decedent's Name (First, Middle, La	st)		Crimoate 0	Death	2. Date of Deat	eg. No.	3. Time of Death
		Physici		Annunziata					Month March 2	Day Year	
		/Medic Examir		4a. Facility Name (If not institution, giv		rrazza	4b. City, Town	n, or Location of Death	march 2	4c. County of Death	3:45 A <sup>M</sup>
				Suburban Hospita	1		Betheso	าใต		Montgomery	
		Funeral		5. Social Security Number 6. S	Sex 7. A	ge (In yrs. last birthd	Months Day	ar If Under 24 Hrs.	8. Date of Birth (Month, Day,	9. Birthi	place (State or Foreign
		Director		028-32-5002	I □ M 2X F	89 <sup>Yrs</sup>	. Months Day	ys Hours Will.	Nov. 30		tland
		and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town o	Location				10d. Inside City Limits
		Manyl f sho	ō	Maryland Montgome							1 X Yes 2 □ No
		28a-	Directo	Maryland   Montgome	ery	Bethesd	a 10f. Zip Code	9	1	0g. Citizen of What Cou	ntrv?
		h with	D	6524 Wicasset Ro	ad		208			U.S.A.	,
		deat	Funeral	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S.		of Hispanic Origin? (Sp uban, Mexican, Puerto	ecify Yes or No-	14. Race - Americ	
	9	after or Ite	Fu	1 Never Married 2 Married	1 Tes 2 X	No	1 ☐ Yes 2 ☒ N		Hican, etc.)	Black, White,	etc.
	8	ural',	d by	3 Midowed 4 ☐ Divorced	Year or Dates:					Specify: Whi	te
	15-	n 72 "nat	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a. De	cedent's Usual Occi ive kind of work dor	cupation ne during most of work ired)	ing	16b. Kind of Business/In	dustry
	12	withi iene. then	duo	Elementary/Secondary (0-12)	College (1-4or	5+) ""	Stitch			Clothing	
	Maryland 21215-0036	filled Hyg other	Be C	17. Father's Name (First, Middle, Last,	)		DELECTI	18. Mother's Name	e (First, Middle, M		
	lan	uld be fenta rked ric ev	TOB	Francesco Valeri	_o			Rosalin	a Mancir	ni	
	ary	should have		19a. Informant's Name/Relationship (	Type, Print)	19b. M	ailing Address (Stre			City or Town, State, Zip	Code)
	Σ	and 2 salth in 27 I		Frank Marrazza (	(Son)			t Rd., Bet	hesda, M	ID 20816	
	Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23s or 28s-f show any Injury or other traumatic event. It a Nedical Examinat must be notified at once.		20a. Method of Disposition 1	Removal from State	20b. Place of Di cemetery, o	sposition (Name of trematory or other p	place)	Date	20c. Location - City or To	own, State
	Ë	Pag iment tant: jury c		`4 ☐ Donation 5 ☐ Other (Specif		1	n Cemeter	y 3/29	/05	Everett, MA	Δ
	3ali	ermit Jepari npor ny In		21. Signature of Funeral Service Licer	1500		22. Name and Add Cota-Str	dress of Facility UZZIETO Fu	neral Ho	nme	
		0.05.80		Jennie (	Julian	cu !	197 Wash	ington St.	, Somerv	ille, MA 02	
				23a. Part1. Enter the disease, or com shock, or heart failure. List only	one cause on ach i	d the death. Do not ne.	enter the mode of d	lying, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
		Pnysician /Medical	P Y	Immediate Cause (Final disease or condition resulting in death)	a. tev	nooshae	ic s	tooke.			Orison and Death
3		Examiner			Due to (or as	a consequence on)	00140 000	day!	Mare	tian	
1.45 NM			er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequence of):	r vogre car		1	4	160
3:		uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	. 17	moons	cy toes		V	W 11	218230)
	0,	certiticate be executed Iding physician and Ise as the burial-transit	Еха	resulting in death) Last	Due to (or as	a consequence of):	1			VIII 1	91
<u>13</u>	8760,	ate be nysicii he bu	dicai	(	d. Lei	J COCYAD!	75.			Sing	٦
707	9	artitics ing ph e as t	Med	IF FEMALE:				_		(100)	
30	8 8 8	w requires that the death certifu been signed by the attending f should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 □Ectopic pregnar			23d. Date of delive Month	ry Day Year
ત્ર	0	the a	ysic	1 ☐ Yes 2 No 9 ☐ Unknown	4□Pregnant a 9□Unknown	t time of death	5 ☐ Other (specify)			Mortan	Day rear
+	4	requires that the death een signed by the atter nould be detached for u	Ph	Part II. Other significant conditions of	ontributing to death b	out not resulting in the	underlying cause o	niven in Part I	23a. Did tob	acco use contribute to the	ne cause of death?
- 2	Vital Records,	uires sign Id be	d by	11 - 1	usran	<b>-</b>		gives in real is	1 □ Ye	. /	ably 4 Unknown
N2	COL	w req beer shou	Completed	Hio D	achne.				24a. Was ar	/	
2	Re	yelcian: The law is certiticate has b director, page 2 s.	Jub	Col dia		matom	)		autopsy	led?   death?	psy findings available apletion of cause of
0	tal	. 42 CT	Be Co	25. Was case referred to medical	ou ru	77000770	14	26. Place of Death	1 Yes 2	/-	2□ No
A		Phyelcian: this certitic al director,	To B	examiner? 1 ☐ Yes 2 <b>1</b> € No	Hospital: 1 Minpatio	ent 2 ER/Outpat	ient 3□ DOA C	N		nce 6 Other (Specify	()
ج	n of	ding Phye T. Atter this funeral did		27. Manner of Death	28a. Date of Inju	ry 28b. Time	of 28c. Inj		28d. Describe ho		/
7	io io	Attending ir death, ector: Attei by the fune	atic	1 Natural 5 Pending investigation	1	, , , , , , , , , , , , , , , , , , , ,		Yes 2 No			
W	Division	tter det	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	286. Place of In	ury · At home, farm, c. (Specify)	street, factory, office	е	28f. Location (Str City or Town,	eet and Number or Rura State)	Route Number,
-		pital ours a sral C									
Marrazza, Annunziata		To the Hospital or Attending Ph within 24 hours atter death, To the Funeral Director: Atter th completely filled in by the funeral	edicai	29a. Certifier  (Check only one)  12 Certifying Ph 2 Medical Exam	niner: On the basis o	t examination and/or	ath occurred at the investigation, in my	time, date and place, a opinion, death occurr	and due to the ca ed at the time, da	use(s) and manner as st te and place, and due to	ated. the cause(s)
$\leq$		o the ithin of the omple	Med	29b. Signature and title of certifier	and manner st		29c. Licer	nse number	29	d. Date signed (Month, i	Day Year)
		F 5 F ŏ		> HX xued	1	Mo	De	53691		March.	20.2005
		5		30. Name and address of person who	completed cause of o	leath (Item 23a) (Tvr	e, Print)	0	. 1		110 2 -0
		ン		AJAN REPOY	nu,	6320	Democ	roy BIV	d, 15	March.	W 20817.
		Sta		31. Date filed (Month, Bay Year) 20	Registr	ar's Signature		J			
		Registra	ar 💮	.0 0 20.	MARIE LAG	1 25 20					

	1	For State Registrar	State of	f Maryland		artmen <i>tificat</i>			and M		giene Reg. No	Z U U ::	010192
Physicia /Medica	n	1. Decedent's Name (First, Middle Jean Marsh	, Last)							2. Date of Dea Month March		<sup>y</sup> 2005 <sup>Yea</sup>	3. Time of Death 6:30pm M
Examine	er	4a. Facility Name (If not institution Greater Balti	more Medi	cal Cent		Tows	on	Location o			В	County of De	re
Funeral Director		5. Social Security Number 076-09-9627 Usual Residence of Decedent	6. Sex 1 ☐ M 2 ☑ F	7. Age (In yrs. las 83	Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Birt (Month, Day Aug 5,	<sup>n</sup> 1 <sup>9</sup> 2	1 N	Sirthplace (State or Foreign Country) ew York
the Maryland 28e-f show	.	10a. State 10b. County MD Balt  10e. Street and Number	imore		Town or Lo						10a. Cit	tizen of What (	10d. Inside City Limits 1 ☐ Yes 2 ☐ No Country?
	7	13801 York Roa  11. Marital Status  1 □ Never Married 2 🕅 Marri	12. Was Dece Armed Fo ed 1 Tyes	2 X No			lent of Hi			ecify Yes or No- Rican, etc.)		Black, Wh	merican Indian, hite, etc.
thin 72 hours e. an 'natural', Medical Exa	Completed by	3 Widowed 4 Divorced  15. Decedent (Specify only highes Elementary/Secondary (0-12)	t grade completed) College (1	ates: -4or 5+)	16a. Deced (Give life. L	kind of wo DO NOT us	Il Occupa rk done d se retired,	Specify: ation furing mos	t of worki	ing	16b. K	Specify: lind of Busines	White ss/Industry
ranu Z I	To Be Con	12 17. Father's Name <i>(First, Middl</i> e, 1 Ray Elamson	Last)	5+	pr	ofess	or			e (First, Middle, e Cutle:		Sumame)	1ege
OIC, Maryld ges 1 and 2 should lost to Health and Menin if itam 27 is marken or other traumatics.		19a. Informant's Name/Relationst Edward Marsh/s  20a. Method of Disposition 1 □ Burial 2 □ Cremation	oouse	con		01 Yo	rk R	oad C	-13	al Route Numbe Cockeys Date	vi1		21030
permit. Pages 1 Department of P Importent: If its any injury or ot once.		4 Donation 5 ☐ Other (S) 21. Signature of Épheral Survice (	ecify)	izégtor	S	Name an tate a ltime	Anat	omy B	y oard 2120	655 W.	Ва	ltimore	e Street
Physician /Medical Examiner		23a. Part1. Enter the disease, or shock, ar heart failure. List Immediate Cause (Final disease or condition resulting in death)	a. a.	aused the death. ach line. or as a conseque	iscul				cardiac d	or respiratory are	rest,		Approximate Interval Between Onset and Death
	Ical Ex	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (	or as a conseque	ntest	\na		blee	dia	5			1 week
wrequires that the death certific been signed by the attending pshould be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 MrNo 9 □ Unknown	1 ☐ Live b	come of pregnance irth 2  Fetal de ant at time of deal own	eath 3□	Ectopic pr Other (sp						23d. Date of d Month	lelivery Day Year
wrequires that the been signed by should be deta	2	Part II. Other significant conditio	ns contributing to de	eath but not resulti	ing in the ur	nderlying c	ause give	n in Part I.			es 2		to the cause of death?  Probably 4 Unknown
Physician: The law re this certificate has ber al director, page 2 sho	Completed										sy med? 2 No	death?	autopsy findings available o completion of cause of as 2 \( \text{No} \)
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funarel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	90	25. Was case referred to medical examiner? 1	28a. Date of (Mont) ation		3/Outpatien 8b. Time of Injury		Bc. Injury Work	r: 4□ Nu	rsing Hor	n <i>(Check only or</i> me 5 ☐ Resid 28d. Describe h	ence		ecity)
ital or Attura after de rel Diracto	Certification;	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	ned 286. Place buildir	of Injury - At hom ng, etc. (Specify)					12	City or Tow	n, State	)	Rural Route Number,
To tha Hospital or Attending Fwithin 24 hours after death. To tha Funarel Director: After completely filled in by the funare.	Medical	29a. Certifier (Check only one)  2 ☐ Medical to the continue of centifier  2 ☐ Medical to the continue of centifier	g Physician: To the Examiner: On the ba and mann										
<u> </u>		30. Name and address of person of	who completed caus	e of death /Item 2	3a) /Tuna	Print)	DS	.02	32	lle M		3/20/	5
- Ctox		CYRUS HAMIDI 31. Date filed (Month, Day, Year)	, M)	13801 egistrar's Signatur	YOR	KR	PC	ocle	ySV	lle M	P	21030	2
Stat Registra	_	MAR 25	2005	Evas B	Sp	sele							

			1 - For State Registrar	State of M		artment of H <i>rtificate of l</i>	lealth and Mer Death	ntal Hygien Reg. N	2005	10193
	Physici	20	1. Decedent's Name (First, Middle				2.	Date of Death	ay Year	3. Time of Death
	Physici /Medio		Willis	MORG				3 2	1 2005	035
	Examin	ier	4a. Facility Name (If not institution,	give street and number; - UMMC		4b. City, Town, or	Location of Death	40	c. County of Death	
	Funeral		110	6. Sex 7. Ag	ge (In yrs. last birthday)			Date of Birth	9. Birthp	lace (State or Foreign
	Director		280-20-7048 Usual Residence of Decedent	1 <b>½</b> M 2□F	79 Yrs.	World Days	Hours Min. JA	Date of Birth (Month, Day, Year N. 28, 1	926 Ohio	) 
	yland		10a. State 10b. County		10c. City, Town or Lo	ocation			1	0d. Inside City Limits
	Ba-f el	Director	W. VA. Berk	.ey	Hedgesvi	lle				1 ☐ Yes 2X No
	hours after death with the Maryland tural', or itema 23a or 28a-f ehow at Examinativet betratified at		10e. Street and Number 20 Border Avenu	le		10f. Zip Code 25427		10g. C	itizen of What Cour USA	itry?
	tema ;	Funeral	11. Marital Status	12. Was Decedent Armed Forces	,	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Specify n, Mexican, Puerto Rica	Yes or No-	14. Race - Americ Black, White,	
980	urs afte	by	1 ☐ Never Married 2 📉 Marrie 3 ☐ Widowed 4 ☐ Divorced	If Van Care	U.S. Navy	1 ☐ Yes 2 🔀 No	Specify:			hite
Maryland 21215-0036	72 hours "natural", dical Ex	Completed	15. Decedent' (Specify only highest	Education	16a. Dece	dent's Usual Occupa	furing most of working	16b. F	Kind of Business/Ind	dustry
121	within ene. than	Jumo	Elementary/Secondary (0-12)	College (1-4or	5+) /ife.	DO NOT use retired	Maintenan	GO C M	Darta	
1d 2	othe ent,	Be Co	17. Father's Name (First, Middle, L	ast)	GCII• I	OLGIMIT O	18. Mother's Name (Fir		Parts n Sumame)	
ylar	should be nd Mental marked c	ToE	Joseph Patterso	n Morgan			Mae Sansen			
Mar	S a a	g i	19a. Informant's Name/Relationsh  Carrie Morgan -				and Number or Rural Ro			
	1 an Heal em 2 ther		20a. Method of Disposition		20b. Place of Dispo		ue, Hedgesv		Va. 254 ocation - City or To	
Baltimore,	Pa ant Lry		1 ∑Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (Sp	ecify)		Cemetery		05 Mart	insburg,	W. Va.
Bal	permit. Departr Importa any inji		21. Signature of Funeral Service L	i lensee	Ga	2. Name and Addres YY L. Kau 50. Washin	s of Facility fman Funera gton Blvd.,	l Home @	Meadowrid	lge MP, Inc.
			23a. Part1. Enter the disease, or c shock, or heart failure. List o	omplications that cause nly one cause on each li	the death. Do not ent	er the mode of dying	g, such as cardiac or res	spiratory arrest,	e, MD 21	Approximate Interval Between
H	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Com	o) ication	is of	HeavI	Luch	(subdray)	Onset and Death
	Examiner			Due to (or	a consequence of):			,		/
-	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		a consequence of j.			11/	/	
ó	tificate be executed g physician and as the burial-transit		that initiated events resulting in death) Last	c Due to (or as	a consequence of):		N.	111	red like?	
68760,	cate be	edical		d			C'MI.	V	WE CALE	
	eath certifi attending     for use as		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			1	at a	3d. Date of deliver	0,
Box	To the Hospital or Attending Physician: The law requires that the death cern within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 4□Pregnant at 9□Unknown		Ectopic pregnancy Other (specify)	*	TOM REPER		Day Year
P.O.	that the	Phy	9 ☐ Unknown  Part II. Other significant condition		ut not resulting in the u	oderh nor cause anyo	o in Part I	200 Did tobacco	use contribute to the	a square of death?
Division of Vital Records,	quires in signe	d by	1	ahim (	war Lur	(S)	II II Faiti.		-	ably 4 Unknown
900	awrec is bee 2 shou	plete	J			7		24a. Was an		sy findings available
ž	The page	Completed						autopsy performed? 1 ☐ Yes 2 ☐ No	death?	pletion of cause of
Vita	sician	Be	25. Was case referred to medical examiner?	Hospital:		• 3CI DOA Othe	26. Place of Death Ch	, ,		
o	g Physer this eral di	n: To	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of Inju		1 3 DUA	4   Nursing Home	5 Residence Describe how injur		11
sior	eath. or: Aft	Certification;	1 Natural 5 Pending 2 Accident investiga	117 10	y Year) Injury	Work M 1 □ Y	es 2 No	e 61	from )	addi
Ξ	l or Att atter d Direct I in by i	ertific	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ed 286. Place of Influence building, et	ury - At home, farm, str. c. (Specify)	eet, factory, office		City or Town, State	nd Number or Rural	
_	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier 1 Certifying	Physician: To the best	T Home of my knowledge, death	occurred at the time	a date and place and d	tue to the cause/s	A BEKKLE	itad
	To the Hospita within 24 hours To the Funeral completely filled	ledical	one)	caminer: On the basis of and manner sta	r examination and/or inv	estigation, in my op	inion, death occurred at	the time, date and	d place, and due to	the cause(s)
	To To con	Σ	29b. Signature and title of certifier			29c. License		29d. Da	te signed <i>Month</i> , D	Day, Year)
	IXI	Ī	30. Name and address of person w	へい Mり no completed cause of d	eath (Item 23a) (Type	276	37753	5	121/200	3
	4,		Jove, watc	INT MD	272 JAG		22 S. Gr	seve St }	30 hourse	MD21201
	Stat Registra		31. Date filed (Month, Day, Year)	32. Registra	ar's Signature					
DHA	MH 17 Rev 1/20		MAR 252	2005	St 1900	No.				

ORIGINAL

			1 - For State Registrar	State of Maryland / [	Department of Health and Certificate of Death	•	
	Physici /Medic		1. Decedent's Name (First, Middle, Last) WAYNE		MARTIN	MARCH 2	ay Year 3. Time of Death 2, 2005 11:45 A M
	Examin Funeral Director		4a. Facility Name (If not institution, give s THE JOHNS HOPFIN 5. Social Security Number 6. Sex	S HOSPITAL  7. Age (In yrs. last bir	4b. City, Town, or Location of Dea  BALT I MORE  thday)  If Under 1 Year If Under 24 Hr.  Months Days Hours Mir	CITY s. 8. Date of Birth	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygeine. Importent: If item 27 is marked other than "naturel; or Items 23e or 28e-1 show any injury or other treumatic event. The Modical Exportent must be notified anonce.	To Be Completed by Funeral Director	Usual Residence of Decedent  10a. State  10b. County  Pennsylvania Allegh  10e. Street and Number  443 Marlin Drive  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  15. Decedent's Educ  (Specify only highest grade  Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Last)  Roy W. Martin  19a. Informant's Name/Relationship (Ty)  Mrs. Resa Jill Mar  20a. Method of Disposition  1 Burial 2 Cremation 3 R  4 Donation 5 Other (Specify)  21. Signature of Funeral Service License	2. Was Decedent Ever in U.S. Armed Forces? 1 Syles 2 Sol No 172-192 If Yes, Give Year or Dates: cation completed) College (1-4or 5+) 4  De, Print) tin (Wife)  amoval from State  Green	Decedent's Usual Occupation  (Give kind of work done during most of wife. Do NoT use retired)  Engineer  18. Marlin Drive, Pit Disposition (Name of ry, crematory or other place)  Mount Cemetery 3/2  22. Name and Address of Facility Mitchell—Wiedefeld	Specify Yes or No- Into Rican, etc.)  Into Rican, etc.)	10d. Inside City Limits  1
760, 8	Medical Examiner  be executed / Medical Examiner  be prijal-itansit	cal Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  5.20usnits it structures if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	of):		Onset and Death
.O. Box 68	death certifica e attending ph id for use as th	hysiclan/Medi	JF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery  Month Day Year
Ф	The law requires that the the has been signed by the bage 2 should be detache	ру Р	Part II. Other significant conditions cor	tributing to death but not resulting i	n the underlying cause given in Part I.		o use contribute to the cause of death?  2 No 3 Probably 4 Unknown
Il Records,		Completed				24a. Was an autopsy performed? 1 Yes 2 X	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
Division of Vital	r Attending Physician: 1 ter death. rector: After this certifical by the funeral director, p	Certification: To Be	25. Was case referred to medical examiner?    Yes   2 No   F		Other: 4   Nursing	eath (Check only one)  Home 5  Residence 28d. Describe how inj  28f. Location (Street a City or Town, Sta	ury occurred  and Number or Rural Route Number,
O	pitel o	edical Cer	29a. Certifier X Certifying Physic (Check only 2 Medicel Examin	sician: To the best of my knowledgener: On the basis of examination ar	e, death occurred at the time, date and placed or investigation, in my opinion, death occurred.	ce, and due to the cause( curred at the time, date a	s) and manner as stated.  Individual stated is a stated in the cause (s)
	within 24 ho To the Fund Completely for	Med	29b. Signature and title of certifier  30. Name and address of person who co	and manner stated.  M. D.  Impleted cause of death (Item 23a)	29c. License number  DC05/364  (Type, Print)	Ma	state signed (Month, Day, Year)  10h 22, 2005
	Sta		Jonathan Powe 31. Date filed (Month, Day, Year) MAR 2 5 2005	32. Registrar's Signature	(Type, Print) TH WOLFE STREE  According	=1, BALIL	MURE, MU 2128/

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	ertificate o				iene g. No.	5 10195
			Decedent's Name (First, Middle, Las	t)					2. Date of Death	า	3. Time of Death
	Physic /Medi		BARBARA LEM			,			Month March 2	Day Ye 20, 2005	6:15 P <sup>M</sup>
	Exami	ner	4a. Facility Name (If not institution, give			4b. City, Town	, or Location	of Death		4c. County of D	
	Funeral		519 Murdock Roa  5. Social Security Number 6. Se		(In yrs. last birthday	Annes		24 Hrs.	8. Date of Birth		ore County
	Director			TM 2DE	58 Yrs.	Months Day	s Hours	Min.	Month, Day, June 2.		Birthptace (State or Foreign Country) ennsylvania
	pug w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation			ourc a,	121011	
	Maryla 1 sho	ō		ce County	Annes						10d. tnside City Limits 1 ☐ Yes 2 ☐ No
	r 28e	Director	10e. Street and Number	ic oddirey	Atmes	10f. Zip Code			10	g. Citizen of What	A
	23a c	al D	519 Murdock Road	1			21212			USA	A
	er dea	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		Was Decedent of	Hispanic Ori Iban, Mexicar	igin? (Spe	cify Yes or No- Rican, etc.)	14. Race - A	merican tndian, /hite, etc.
36	irs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 1 No tf Yes, Give X Year or Dates:	0	1□Yes 2√N				Specify:	White
Maryland 21215-0036	be filad within 72 hours after death with the Maryland nat Hygiene. d other than "neturel", or Items 23a or 28e-1 show event, the Mcdical Examinating the notified at		15. Decedent's Ed	ucation	16a. Dece	edent's Usual Occ	upation		1	6b. Kind of Busine	
215	within 7 iene. than "r	Completed	(Specify only highest grad	Coltege (1-4or 5+	life.	kind of work don DO NOT use reti	red)		9		,
72	filad w Hygier ther th		17. Father's Name (First, Middle, Last)	4 yrs	Medi	.cal Tech				Medic	cal
and	Duid be f Mental H arked ot atic ever	o Be							(First, Middle, M	aiden Sumame)	
ary	2 should be and Mental Is marked eumatic ev	户	Kenneth Lemlev  19a. Informant's Name/Relationship (T	ype, Print)	19b. Mail	ing Address (Stree	Man et and Numbe	cy Cr	addock Route Number	City or Town, State	e. Zin Code)
	5 를 Z 를 고		Dr. Barton C. McC	ann (Husba	forest sur-						
Baltimore,	gas 1 av t of Hea If item or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ I	,	20b. Place of Disp	osition (Name of matory or other pi	ace)	Da	ite 2	0c. Location - City	or Town, State
ţi	Pagas tment of tent: If it		`4 Donation 5 ☐ Other (Specify,	)	Dulaney	Valley M	1em Gro	ins 3	/23/05 1	imonium.	Maryland
Bal	permit. Page Department Importent: If any injury o		21. Signature of Funeral Service Linears	auson	2	<ol><li>Name and Add</li></ol>	ress of Facilit	у		Home, In	Control of the Automotive Control
			Martin D. Laws	011	he death. Do not en	500 York	Road.	Bal	timore.	Maryland	12.12 mate
3	Pnysician	ď	tmmediate Cause (Finat	ne cause on each line	).				respiratory anes	м, э	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a Due to (or as a	consequence of):	LYMPI	1071				6 4R1
L	Examiner		Sequentially list conditions,	b							
	ad isit	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of).						
	xacut and	xan	that initiated events resulting in death) Last	c Due to (or as a	consequence of):						
8760,	cate be exacutad ohysician and the burial-transit	dlcal E									
9	tiflicat ng phy as th	ledi		V							
P.O. Box	that the death cartifi ed by the attending of detachad for use as	Physiclan/Me	Lob. Was decedent pregnant	23c. If yes, outcome of 1□Live birth 2		Ectopic pregnanc	CV.			23d. Date of c	delivery
о П	ne dea the at had fo	/sicl	in the past 12 menths? 1 □ Yes 2 th No 9 □ Unknown	4☐ Pregnant at til 9☐ Unknown		Other (specify)	-,			Month	Day Year
٥.	Tha law requires that the death cardificate has baen signed by the attending page 2 should be detached for use as	Ph	Part II. Other significant conditions co	ntributing to death but	not resulting in the u	ndertving cause g	ven in Part I	-	23e Did toba	cco use contribute	to the cause of death?
Vital Records,	luires than signed	d by	CONGENTUE		FAILUR				1 🗆 Yes	10	Probably 4 Unknown
CO	law requir as baen si 2 should	olete							24a. Was an	24b. Ware	autopsy findings available
R	Tha lay ata has bage 2 :	Completed							autopsy performe 1 Yes 2	prior to	o completion of cause of ?
/ita	ysicien: Tha is certificata ha director, page	Bec	25. Was case referred to medical examiner?				26. Place	of Death (	Check only one)		35 20 110
7	Physic this co	2	1 □ Yes 2 ☐ No		2 ER/Outpatier	1 3 DOX				ce 6 □Other (Sp	pecify)
	ding I h. After funer	tlon:	27. Manner of Death  1 Naturat 5 □ Pending	28a. Date of Injury (Month, Day )	(ear) 28b. Time of Injury	Wo	ıryat ork? ]Yəs 2.∐N		d. Describe how	intury occurred	
Division	I or Attending Physicien: after death. Director: After this certifica i in by the funeral director.	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Ptace of Injury	- At home, farm, str				f. Location (Stree	et and Number or I	Rural Route Number,
ā	tal or s afte el Dir	Cert	4  Homicide determined	building, etc.	(Specify)	,,			City or Town, S	State)	
	To the Hospital or A within 24 hours after To the Funerel Dire completely filled in by	edical (	29a. Certifier Certifying Physical Exami	sicien: To the best of ener: On the basis of ener:	my knowledge, death	occurred at the t	ime, date and	place, an	d due to the caus	se(s) and manner	as stated.
	To the h within 24 To the F complete	Med		and manner state	d.			n occurred			
	¥		29b. Signature and title of certifier	MO		29c, Licen		۵	29d	Date signed (Mor	
	0,	-	30. Name and address of person who co		th (Item 23a) (Type		2773	0		3/22/0	/ 3
	1		Gary Cohen, M.D.,			ř	Towso	on, M	aryland	21204	
	Sta		31. Date filed (Month, Day, Year) MAR 2 5 20						¥		
	Registra	ar I	IN C & AMINI	JUJ JAMES	1 15 pm						

			1 - For State Registrar	State of I	Maryland	-	artmen rtificat					jiene leg. No	005	10	96
	Physici	ian	Decedent's Name (First, Middle, Li								2. Date of Dea Month	Day	Year	3. Time of	Death
1	/Medi		PAUL BOYD MULES								March 2	3, 200	5	5:35A	М
*	Examir	ner	4a. Facility Name (If not institution, gi	e street and numbe	er)		_	_	Location o	of Death		4c. Co	ounty of Death		
				Sex 7.	Age (In yrs. Ia	ast hirthday)	If Under	OWSOr 1 Year	If Under:	24 Hrs.	9 Date of Birth		Baltim		- Caroles
	Funeral Director			XX M 2□F 7		Yrs.	Months	Days	Hours	Min.	8. Date of Birtl (Month, Day AUGUST 19	$\frac{1}{2} \frac{Y_{\theta ar}}{1920}$	Col	iplace (State o intry) 1 and	r r-oreign
			Usual Residence of Decedent								ugust i.	- 152	J Huly	1010	
	nylan	_	10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside Ci	•
	Ba-f e	cto	Maryland Baltimor	e	Tc	owson								1 🗆 Yes	%XXX°
	rs after death with the Marylan F, or Hems 23a or 28a-f ehow	Funeral Director	10e. Street and Number				10f. Zip					0g. Citize	n of What Cou	intry?	
	s 23s	rai	800 Southerly Road	10 111 - 1				2128		1010			USA		
	Item de	Ę.	11. Marital Status 1 ☐ Never Married 2/1 Married	12. Was Decede	ont Everin U.≿ es? □ No. IIIT	5. 13.	Mas Deced f Yes, spec	ent of Hi	spanic Orig n, Mexican	gin? (Spec i, Puerto R	ify Yes or No- ican, etc.)	14.	Race - Amer Black, White		
336	urs af	by	3 ☐ Widowed 4 ☐ Divorced	MYYes 2[ If Yes, Give Year or Date	is:		1□Yes	2 <b>XX</b> N0	Specify:			Sp	pecify: W	hite	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-1 ehow ite Medical Exertines: ast be redified at	Completed	15. Decedent's E			16a. Deced	dent's Usua	l Occupa	tion			16b. Kind	of Business/l	ndustry	
21	thin 7	nple	(Specify only highest gr Elementary/Secondary (0-12)	College (1-40	or 5+)			e retired	uring most	t of working	9				
21	fited with Hygiene. Ither than	Son		5+		Sal	.esman						Pap	er	
Maryland	should be filed withir of Mental Hygiene. marked other than imatic event, the M	Be	17. Father's Name (First, Middle, Las Paul Boyd Mules Sr	")						ene Joh	(First, Middle,	Maiden Su	mame)		
ž	should nd Men marke umatic	10	19a. Informant's Name/Relationship	(Tuna Drint)		10h Mailia		(Canada				0	2	0 4 1	
Ma	d 2 sho th and t7 le m traum		Marie Schisler Mules		Wife						Route Numbel On Maryla	-		р Соде)	
<u>6</u>	s 1 and 2 should be filed within if Health and Mental Hygiene. Item 27 le marked other than other traumatic event, the M		20a. Method of Disposition		20b. Pfa	ace of Dispo	sition (Nan	ne of	u #012	L TOWSC Da			200 tion - City or T	own, State	
altimore,	e ° = 5		1 Burial 2XX Cremation 3 [ A Donation 5 Other (Speci	Removal from Sta		metery, cren enMount				3/24/05	,	Ral+in	nore, Mai	cul and	
Ħ.	프 된 문 글 .		2 signature of Funeral Service Lice		/ .		. Name an				chell-Wie				~
ä	Depa Impo any i		Junis Dysko	n Kenas	Res				6500		Road Bal				
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that caus	sed the death.	. Do not ente	er the mod	e of dying					,	Approximate Interval Bety	
	Pnysician	6.3	Immediate Cause (Final disease or condition		2	20.400	14200						31	Onset and D	
1	/Medical Examiner		resulting in death)	Due to (or	as a con equ	erce of):	1	-	1		A .	-4		12	
	Examine	_	Sequentially list conditions, if any leading to immediate	b. —	00	1/21	ne	un'	1/1/	re	P) eme	ula	4	Ly	1
	ted nsit	Examine	cause. Enter Underlying Cause (Disease or injury	Due to for	as a conse u	ense on:	L	1	5					101.	11
	be executed sician and burial-transit	xar	that initiated events resulting in death) Last	c. Due to (or a	as a cons	ence of):	-	1000	1	5341			-	109	,
8760	death certificate be executed e attending physician and nd for use as the burial-transit			d.											
9	tificate ng phys as the	Physician/Medical													
Вох	eath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	ne of pregnan 2 DFetal		Ectopic pr	egnancy				23d	Date of deliv	•	
	the at	sici	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		at time of dea		Other (spe						Month	Day Y	ear
P.0	that the ded by the detached		Part II. Other significant conditions	contribution to death	hut not resul	lting in the ur	derhina es	auca awa	n in Part I		23e Did tol	acco usa	contribute to 1	he cause of de	ath?
Vital Records,		1 by	and its officer of the state of	John Dalling to abati	T Dut Hot 16301	ang in me ui	idenying ca	3U30 GIVO	.,		1 🗆 Ye		_	bably 4 ∏U	
Sor	law requires as been sign 2 should be	ete									24a. Wasa		4h Mora auto	nov findings	uadabla
Re	0 L 0	Completed									autops perforr	y ned2	death?	opsy findings a impletion of ca	use of
ta	tician: Th certificate rector. pag	0	25. Was case referred to medical						26 Place	of Death /	1 ☐ Yes 2	No	1 🗌 Yes	2□ No	
<u> </u>	S S	O B	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpa	atient 2 🗆 E	R/Outpatien	3 DO	A Othe	/		o 5 ☐ Reside		Other (Speci	(v)	150
n of		T: T	27. Manner of Dean 1. Natural 5 □ Pending	28a. Date of In (Month, L	njury Day Year)	28b. Time of Injury	21	Bc. Injury Work	at ?	28	d. Describe ho	w injury o	ccurred	,,	
Sio		atlc	2 Accident investigation	n			М		es 2 🗆 N	No					
Division	I or Atten after deat Director: I in by the	Certification;	3 Suicide 6 Could not be determined	286. Place of	Injury - At hon etc. (Specify)	ne, farm, stre	et, factory	, office		28	f. Location (St City or Town	reet and N , State)	umber or Run	al Route Numb	PBF,
	Hospital 4 hours a Funeral C		29a. Certifier 1X Certifying P	veicine. To the be	at of my know	dadaa daas				(1)	1122				
	e Hos 24 hc e Fun etely	Medical	(Check only 2 Medical Exa	nysician: To the bearing: On the basis and manner	of examination	on and/or inv	estigation,	in my op	e, date and inion, deat	n piace, an h occurred	d due to the ca Lat the time, da	tuse(s) and ate and pla	d manner as s ice, and due t	tated. o the cause(s)	
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Me	29b. Signature and title of certifier	0	_		29c	License	number		2	9d. Date si	gned (Month,	Day, Year)	
			<b>)</b> / /	// 1	<u> </u>	Lame	5.	1).	29	769	7	-	3/2	3/05	-
	V		30. Name and address of person who	completed cause o	f death (Item)	23а) (Туре, І	Print)	7 -	h	/	, 1		11 .	12.	
	*		mrichas D	Albue	me	w	5/	6 9	r. Ko	/ Can	kd	346	to as	17	228
	Sta Registr		MAR 2 5 201		strar's Signatu	Ire Ange	L			J					

Baltimore, Maryland 21215-0036

	D. N/A BALTIMORE  6. Street and Number  O.23 PALMER AVENUE  10. Zip Code  212.15  U.S. OF A.  Martial Status  112. Was Decedent Ever in U.S. Armed Forces?  113. Was Decedent of Hispanic Origin? (Specify Yes or No. 14. Race - American Indian, Black, White, etc. 1) Lip word Martial Country  114. Race - American Indian, Black, White, etc. 1) Lip word Martial Country  115. Was Decedent Ever in U.S. Armed Forces?  116. Decedent's Education (Specify only highest grade completed)  (Specify: BLACK   168. Kind of Business/Industry  (Specify: BLACK   169. Martial Status  169. Name (First, Middle, Marden Sumame)  (Industry and Number of Pural Route Number, City or Town, State, Zip Code) 21208  720 PRESSTE HITCHINSON  189. Martial state of Deposition (Number)  199. Martial state of Positive Specify: Annual Number of Pural Route Number, City or Town, State, Zip Code) 21208  721 Partial State of Deposition (Number)  120. Number of Pural Route Number, City or Town, State, Zip Code) 21208  721 Partial State of Specify: Annual Number of Pural Route Number, City or Town, State, Zip Code) 21208  722 Part State of Specify: Annual Number of Pural Route Number, City or												
1 _ State		State	n waiyiai						ieman		00	n E	1010
	ame (First, Middle, L	ast)			Crimodi	0011	204177		2. Date of D	eath		UJ.	3. Time of Death
											*	_	510:45 A
4a. Facility Nam	LMINA F e (If not institution, g	VERKINS ive street and nu	ımber)		4b. City,	Town, or	Location	of Death			. Count	y of Deat	h
SINA	HOSP	17AL 0	FBAL	TIMBE	E B	ALT	omi	RE	C17-			N/A	_
					Months				8. Date of E (Month, L	irth ay, Year,	)	9. Birt	hplace (State or Fore
	4172	1 W 2	60	Yrs					JUL.	<b>,</b> 19	44	MAI	RYLAND
10a. State			10c. C	ity, Town or	Location								10d. Inside City Limi
MD.	N/A		BA	LTIM	ORE								F <b>g</b> Yes 2□h
10e. Street and	Number				10f. Zip	Code				10g. Ci	tizen of	What Co	untry?
5023 P	ALMER AV	ENUE				21	215			U	.s.	OF	Α.
11. Marital Statu	ıs	Armed F	orces?	J.S. 1	3. Was Dece	dent of H	ispanic Ori	igin? (Sp	ecify Yes or h	10-			
-	_	1 ☐ Yes	2 No										
3 Widowe			Dates:	1 15 5						1 4			
(S	15. Decedent's pecify only highest g	Education rade completed)	1	16a. De	icedent's Usu ive kind of wo	al Occupi ork done o se retired	ation during mos	t of work	ing	16b. F	kind of E	dusiness/	industry
							,						
			WTM	UNE	MPLOI	עם	18. Mothe	er's Name	e (First, Midd	e, Maidei	n Sumai	me)	
лони о	SCAR CAN	NON. S	R.				JES	SIE	HITCH	IINS	ON		
				19b. Ma	ailing Address	(Street	and Numbi	er or Run	al Route Num	ber, City	or Town	, State, Z	Tip Code) 2120
21. Signature o	meral Service	THATS	T. GWY	ZNN	22. Name ar LEWI	Addres	s of Facili	y YNN	FUNE	RAL	ном	E 2	1215-639
shock, or	neart failure. List on	ly one cause on	each line.			-	man*		PS AVI or respiratory	ENUE arrest,	В	AL'I'(	Interval Between
disease or cond	dition			Service Street Control	ORGI	JM 1	FAIL	JKE				-	3 days
		S	EPTIC	_	Hock								3 dam
Sequentially list if any, leading t	conditions, o immediate	Due to	(or as a conse		( )								-
Cause (Disease that initiated evi	or injury ents	c	HOL AN	GITT	S								7 day
resulting in dea	th) Last	Due to	(or as a conse	quence of):									0
		d											
230. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) Month Day											,		
	_	contributing to o	death but not re	sulting in the	e underlying o	ause give	en in Part I						
*									aut	opsy formed?		Were au prior to death?	completion of cause of
25. Was case re examiner?	eferred to medical		LAGE			7		of Deatl	(Check only				-
1 Tes 2	2 DNO	Hospital:	Inpatient 2	ER/Outpa	tient 3 DC		4   140	ırsing Ho	me 5□Re	sidence	6 🗆 Otl	her (Spec	cify)
27. Manner of D	eath 5 Pending	28a. Date	of Injury oth, Day Year)	28b. Time Injur	e of	28c. Injun Worl	at		28d. Describe	how inju	ry occui	rred	

To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760 Certifi

Physician

/Medical Examiner

**Physici** /Medi Examir

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 le marked other then "neturel", or Itams 23a or 28e-f show eny injury or other treumatic event, the Medical Examinational be invitified at once.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide 29a. Certifier (Check only one)

29b. Signature and title of certifier

29c. License number MD RES-000

to certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

2005

MARCH

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD

MOHAMMAS

31. Date filed (Month, Day, Year)

MAR 2 5 2005 U.

SHARIEF 32. Registrar's Signature

SINAI HOSPITAL BALTIMORE 0 F

Medical

State Registrar

			For State Registrar		State o	f Marylar	•	artmen rtificat			and M	lental Hy	giene Reg. No	005	10198
	Physici /Medic		1. Decedent's Name (First, A Ann Marie P		-				-			2. Date of De Month	Day	2005	3. Time of Death
	Examir		4a. Facility Name (If not institution Carroll Cou			Hospit				Location of				County of Death	
	Funeral Director		5. Social Security Number  214-76-2841  Usual Residence of Deceder		ex □M 2 <b>%</b> □F	7. Age (In yrs. 48	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Bir (Month, Da Dec. 3	, 1956	9. Birth Cou Ger	place (State or Foreign ntry) MANY
	a-f show	ctor	10a. State 10b. Co		el		ity, Town or Lo								10d. Inside City Limits 1 ☐ Yes 2 ☐ Ño
	with the	Dire	10e. Street and Number 5376 Red Ce	dan (	Court			10f. Zip	Code 1784				10g. Citiz	en of What Cou A	ntry?
21215-0036	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene. ortant: if Item 27 is marked other than "natural', or Itama 23a or 28a-f show injury or other traumatic event, the Medical Examinar must be notified at injury or other traumatic event, the Medical Examinar must be notified at @.	Completed by Funeral Director	11. Marital Status  1 Never Married 2 🖔  3 Widowed 4 Divo	Married	12. Was Dec Armed Fo 1 [] Yes If Yes, Gir Year or D	2 ZNo ve	16a Dece	Was Decedif Yes, spec	dent of Hi cify Cuba No	Specify:		ecify Yes or No Rican, etc.)	0- 1-	4. Race - Ameri Black, White	etc. ite
1215	rithin 72 ne. nan "na	nplet	(Specify only h	ghest gra	College (	1-4or 5+)	(Give	kind of wo DO NOT us	rk done d se retired	luring mos )		ring			•
	filed w I Hygier other th	d	12 17. Father's Name (First, Mic	idie, Last,	1+		Exec	utive	ASS			e (First, Middle	-	Healthc Sumame)	are
Maryland	tould be Mental narked o	To Be	Ervin Erdma		Torre Orient	·	10h Maili		/Cam as a			iomas R		Town State 7	Code
Baltimore, Mai	permit. Pages 1 and 2 shr Department of Health and Important: If Item 27 le m any injury or other traum.		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  Alan C. Powers / Husband  20a. Method of Disposition 1   Burial 2   Cremation 3   Removal from State 4   Donation 5   Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Belair Memorial Gardens 3/25/05  Belair, Maryland  21. Signature of Funeral Service Licensee  22. Name and Address of Facility  Fleck Funeral Home, Inc.												
Balti	permit. Pag Department Important: i any injury o once.		21. Signature of Funeral Service Licensee  22. Name and Address of Facility  Fleck Funeral Home,  7601 Sandy Spring Road, Lawrex, Maryx  23a. lart 1. Enter the disease, or complications that care ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.											, Inc.	
760,	Physician //Medical Examiner per unit in transit per unit in trans	23a. Fart1. Enter this disease, or complications that consider the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, index, or hearth liure. List only one cause on each line.  A A A A A A A A A A A A A A A A A A A												Approximate Interval Between Onset and Death 2 M UA W	
.O. Box 687	death certificate e attending phy. id for use as the	Completed by Physician/Medic	IF FEMALE: 23b. Was decedent pregnar in the past 12 pronths? 1   Yes 2 DNo 9   Unknown		1 Live I	tcome of pregn birth 2  Fet nant at time of own	al death 3[	⊒Ectopic pi ⊒ Other (sp			4		23	3d. Date of deliv Month	ery Day Year
<u>α</u>	se us	d by Ph	Part II. Other significant con	ditions	contributing to d	eath but not re	sulting in the u	nderlying c	ause give	en in Part I			tobacco us		he cause of death?
Il Records,	The ate h	Complete has been complete com									24a. Was auto perfe 1 Tes		24b. Were autoprior to codeath?	opsy findings available impletion of cause of	
Vital	Physiclan: The this certificate ral director, pag	o Be	25. Was case referred to me examiner?  1  Yes 2 No	dical	Hospital:	Inpatient 2	] ER/Outpatie	nt 3 🗆 DC	Othe			h (Check only ome 5 ☐ Res		□Other (Speci	fv)
Division of	ding After fune	Certification: T	27. Manner of Death  1 Natural 5 P  2 Accident in  3 Suicide 6 C	ending vestigatio buld not b stermined	28a. Date (Mon		28b. Time of Injury	of 2	28c. Injun Work	/ at k? Yes 2 □		28d. Describe	how injury	occurred	al Route Number,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical C	29a. Certifier 1 Cer (Check only 2 Met	tifying Pl	nysician: To the miner: On the b and man	e best of my kn easis of examin liner stated.	owledge, dea ation and/or in	h occurred ivestigation	at the tim	ne, date an pinion, dea	nd place, ith occur	and due to the red at the time	cause(s) a , date and p	and manner as a	stated. o the cause(s)
	To th Withir To th	Me	29b. Signature and title of co	γ c₀	K. Gc	Qu	iii mo	290	-	number 31	660	5	(	signed (Month)	Day, Year)
	3-6		30. Name and address of pe		GALVIE	v 14	291	STOW	er	ave.	Jue	LUESTA	Mins"	ren n	(Mechad
		State Registrar  31. Date filed (Month, Day, Year)  Registrar  MAR 2 5 2005  AND COMPLETED AND COMPL													

DHMH 17 Rev 1/2001

			For	State of Marylan		artment of F			12	000	I m i i
			Registrar  1. Decedent's Name (First, Middle, Lat	st)	061	incate of	Deain	2. Date of De		<u>UU0</u>	3. Time of Death
П	Physicia		Jerome Parks					Mar. 1	5, 2	005	2:30 PMM
).	/Medic Examin		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, o	r Location of D	Death		ounty of Death	
			5814 Gwynn Oak			Baltim		Hre la Baranta		N/A	
	Funeral Director		5. Social Security Number 6. S 212-48-0214	VIM 2□F	Yrs.	If Under 1 Year Months Days		Min. 8. Date of Bir (Month, Da Sept.	ay, Year)	Cour	lace (State or Foreign try) aryland
			Usual Residence of Decedent	56				pepc.	25,	15,10 11	aryrana
	inylan ihow		10a. State 10b. County	10c. City	y, Town or Lo	cation				1	0d. Inside City Limits 1 XYes 2 No
	he Ma 8a-f s	Director	Maryland N/A	Ba	ltimo	ne 10f. Zip Code			10a Citizo	n of What Cour	
	with t s or 2		10e. Street and Number 5500 Gist Aven	ue		21215	5		-	SA	my:
	2 should be ilied within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or Ilems 23s or 28s-f show aumatic event, the Modical Examinational by notified a	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of H	dispanic Origin	? (Specify Yes or No	p- 14.	Race - Americ Black, White,	
9	after or Ite	/Fu	1 XNever Married 2 Married	1 □Yes 2 XNo	ļ	1 □ Yes 2KD No		dorto rilouri, dio.,	Sı	pecify: Bla	
Ö	hours tural',	d by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's E	Year or Dates:	16a Decer	dent's Usual Occup	nation			of Business/Inc	
7	n "nat	piete	(Specify only highest gra		(Give	kind of work done DO NOT use retire	during most of d)	f working			
212	giene giene er tha	Completed	11th grade 17. Father's Name (First, Middle, Last,		Carp	entry W				Emplo	yeu 
2		Be		)				Name (First, Middle		ımame)	
Maryland 21215-0036	should ind Men s marke umatic	2	Leon Parks  19a. Informant's Name/Relationship (	Tuno Printl	10h Mailir	an Address /Street		ie Tillm or Rural Route Numb		own State Zin	Code)
ā	d 2 st th and th sr traur		Joyce Lewis/ S			Gist A					
ē,	s 1 and f Health item 27 other tr		20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of		Date	20c. Loca	tion - City or To	wn, State
altimore,	Pages nent of I ant: If it		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif	Removal from State Mt.	Zion	Cemete	ry 3,	/22/05	Balti	imore,	Maryland
Balti	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev		21. Signature of Funeral Service Lice	Hari		Name and Addre		Chatman town Rd	-Har Balt	ris Fu imore,	neral Hom Md 21215
			23a. Part1. Bhter the disease, or com shock or heart failure. List only	plications that caused the deat one cause on each line.	h. Do not ent	er the mode of dyir	ng, such as ca	rdiac or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	coron	WY	arter	Y O	iseas	2		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):	5 .	·	itus			
l.	<b>a</b> [7]	er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conseq	uence of):	> Y ?	8 101	11103			
	cuted	Examiner	Cause (Disease or injury that initiated events	. hype	rtex	1510	<u> </u>				
ő,	cate be executed chysician and the burial-transit	Ex	resulting in death) Last	Due to (or as a conseq	uence of):						
8760		dicai	•	d							
9 X0	leath certific attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna		7-			230	d. Date of delive	ry
$\mathbf{m}$	death e atte	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown		Ectopic pregnanc Other (specify)	у			Month	Day Year
о. О.	res that the de signed by the a l be detached f	Phys	9 🗆 Unknown		hi i ai			020 Did	ahaaaa uaa	contributo to th	ne cause of death?
Records,	The law requires that the death certifi ate has been signed by the attending page 2 should be detached for use as	by	Part II. Other significant conditions	contributing to death but not res	uiting in the u	nderrying cause giv	ven in Part i.		Yes 2 1		\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \
ecc	has be	Completed						24a. Was		24b. Were auto prior to col death?	psy findings available apletion of cause of
	tician: The certificate ? rector, pag							1 Yes	2 D No	1 Yes	2□ No
Vita	Attending Physician: r death. ector: After this certifici by the funeral director,	o Be	25. Was case referred to medical examiner?	Hospital: 1   Inpatient 2	ER/Outpatier	nt 3 DOA Ott	200	Death (Check only ing Home 5 ☐ Resi		Other (Specifi	Disters
0	g Physer this leral di	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o		ry at	28d. Describe			home
jo	endin sath. or: Aft he fun	atio	1	n	,,		Yes 2 □ No				
Division of	al or Att	Certification:	3 Suicide 6 Could not be determined		ome, farm, str y)	eet, factory, office			Street and N wn, State)	Number or Rura	l Route Number,
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medicai C		nysician: To the best of my kno miner: On the basis of examina and manner stated.							
	To the To the Comp	Ĭ	29b. Signature and title of certifier	2010 10		29c. Licens	se number	21.1	29d. Date s	signed (Month,	Day, Year)
)	$\cap$		etaulu	JUR MI	<u>)</u>	DO	001	214	Mar	rchl	8,2005
	. }		Eddye Bullo	completed cause of death (Item	Pat	Print) Hevso	n Av	re Ba	ltm	nove	MD
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signa	iure .	P					2190

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1 - For State Registrar	State of Maryla	•	rtificate of			Reg. No.	
Physic		1. Decedent's Name (First, Middle, Las Ruth Porter	()				2. Date of De Month March	Day Em	Year 5 3. Time of Death
/Medi Exami		4a. Facility Name (If not institution, give		s. last birthday)	4b. City, Town, or Ba	r Location of Dea	ath	4c. County o	of Death
Funeral Director		5. Social Security Number 6. Security Number 214-38-3270	ox □M 2XIF 92		Months Days	Hours Mir		, 1912	9. Birthplace (State or Foreign Country) Maryland
Maryland f show	tor	10a. State MD 10b. County	10c. (	City, Town or Lo Baltin					10d. Inside City Limits 1 X Yes 2 ☐ No
h with the 23a or 28a-	Funeral Director	10e. Street and Number 2211 W. Rogers A	venue		10f. Zip Code 2120	09		10g. Citizen of W	hat Country?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 le marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, the Modical Examination until be notified at any injury or other treumatic event, the Modical Examination until be notified at any injury or other treumatic event, the Modical Examination until be motified at any injury or other treumatic event, the Modical Examination until be motified at any injury or other treumatic event, the Modical Examination and the page 2000 or 2000 o	by Funer	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🕅 No		Specify Yes or No irto Rican, etc.)	Black	- American Indian, t, White, etc. white
Dealtillioie, Mailylaind A.I.A.I.S.D.D.D.D.D.D.D.D.D.D.D.D.D.D.D.D.D.D	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)		16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retired	during most of w d)	orking	16b. Kind of Bus	
Id be filed wental Hygie ked other tic event, ID	To Be Co	17. Father's Name (First, Middle, Last) Joshua Lynch	4		teach	18. Mother's Na	ame (First, Middle	, Maiden Sumame	ation
nd 2 shou alth and M 27 le mar	-	19a. Informant's Name/Relationship (1 Joan Raimondi/dau			ng Address <i>(Street</i> Snowberry			2.000	State, Zip Code) 21030
Pages 1 and of Hesen of Hesen of Hesen of Hesen of Hesen of Hesen or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 14 ☒ Donation 5 ☐ Other (Specify	Removal from State	cemetery, cre	osition (Name of matory or other plac	се)	Date	20c. Location - C	City or Town, State
permit. Departr Importe		21. Signatur Funeral Service icent Rona I d	Wade, Arect	2	2. Name and Addre State An Baltimor	e, MD	oard 655 21201	W. Balti	more Street
Physician /Medical		23a. Part1. Enter the disease, or com, shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line.  a. Due to (or as a cons.	RE M	ter the mode of dyir	ng, such as cardi	ac or respiratory a	N71A	Approximate Interval Between Onset and Death
xecuted xecuted al-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. ADVANCED Due to (or as a consi c. DIABETO Due to (or as a consi	CHRO	BROVAS ULITU	CULAR	DI SEA.	SE	YGARS YGARS
eath certificate be executed attending physician and for use as the burial-transit	edicai	IF FEMALE: 23b. Was decedent pregnant	d	nancy etal death 3[	□Ectopic pregnanc	y		23d. Date	of delivery
that the death certifeed by the attending detached for use a	by Physician/M	in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4□Pregnant at time o 9□Unknown		Other (specify)			World	iii Day 16ai
w requires that been signed should be def		Part II. Other significant conditions o	ontributing to death but not r	esulting in the u	anderlying cause giv	ven in Part I.	23e. Did 1	V	bute to the cause of death?  3  Probably 4 Unknown
The faw requires that the death cercate has been signed by the attending page 2 should be detached for use	Completed						24a. Was auto pento 1 🗆 Yes	psy pr ormed? de	fere autopsy findings available for to completion of cause of sath?  ☐ Yes 2 ☐ No
To the Hospital or Attanding Physician: The law requires twithin 24 hours after death.  To the Funeral Director: After this certificate has been signed completely filled in by the funeral director, page 2 should be	tion: To Be	25. Was case referred to medical examiner?  1 Yes 22 No  27. Manner of Death  1 Natural 5 Pending investigation	Hospital: 1  Inpatient 2  28a. Date of Injury (Month, Day Year)	ER/Outpatie	of 28c. Injur	ner: 4 Nursing	1	one) idence 6 Other how injury occurre	
el or Attending s after death. Il Director: After ed in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined						(Street and Number wn, State)	r or Rural Route Number,
he Hospitel in 24 hours a he Funerel i pletely filled	edical		ysician: To the best of my k niner: On the basis of exami and manner stated.						
To the within 2 To the complete	¥	29b. Signature and title of certifier	Rolym.D.		29c. Licens	9425		3/14/	(Month, Day, Year)
		30. Name and address of person who ROBERT E - ROE	34 M.D ZZ	tem 23a) (Type /1 W . E	Print)	AVE-	BALTIM	ORE, M	D Z1209
Si	tate	31. Date filed (Month, Day, Year) MAR 2.5.20	32 Registrar's Sig	mature	will			ī	

			State of Maryland				•	•	1000
			1- State Registrar		rtificate of D			Z U U 5	10201
		3	1.(Decedent's Name (First, Middle, Last)		1	2	Date of Death	Day Year	3. Time of Death
	Physici /Medic		DORDHAY		PAU	6h 1	Aech	23, 2005	17.30 "
	Examin	er	4a. Facility Name (Iffnot institution, give street and number)	/	4b. City, Town, or			4c. County of Deat	h
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last	t birthday)	If Under 1 Year	If Under 24 Hrs. 8.	Date of Birth	9. Birt	hplace (State or Foreign
	Director		219-34-2620 <sup>1□M 2</sup> ÅF 70	Yrs.	Months Days	Hours Min.	JAN . 7	,1935 M	ARYLAND
	and		Usual Residence of Decedent           10a. State         10b. County         10c. City, T	Town or Lo	cation				10d. Inside City Limits
	Maryl -1 sho	to	MD. BALTIMORE	BALT	IMORE				1 □ Yes 2 📉No
	or 288	Director	10e. Street and Number		10f. Zip Code		10	g. Citizen of What Co	untry?
	s 23a	ral	101 CENTRE PLACE APT. 215		212			U.S.A.	dana kadina
	ter de Itemi	by Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married  1 □ Yes 2 ☒ No	13.	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Specif n, Mexican, Puerto Ric	y Yes or No- an, etc.)	14. Race - Ame Black, Whit	
036	al', or	by	3 XWidowed 4 □ Divorced If Yes, Give Year or Dates:		1 ☐ Yes 21X No	Specify:		Specify: WH	ITE
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show that the Madical Examiner must be redilled at	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occupa kind of work done di	tion uring most of working	16	6b. Kind of Business/	Industry
121	within ene. than	omp	Elementary/Secondary (0-12) College (1-4or 5+)		SEWIFE			DOMESTI	С
d 2		Be C	17. Father's Name (First, Middle, Last)			18. Mother's Name (F	First, Middle, Ma	aiden Sumame)	
Maryland		To E	BENJAMIN DICKERSON					H THOMAS	
Mar						nd Number or Rural F EX ROAD , I		•	<sup>Zip Code)</sup>
	tem 27 tem 27 other tr		20a. Method of Disposition 20b. Place	e of Dispo	sition (Name of matory or other place	Date		Oc. Location - City or	
E C	Pages nent of int: If it					NAL 3/28,	/05 B	ALTIMORE	,MARYLAND
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other ti		21. Signature of Funeral Service Licensee	フ ii	Name and Address JLLY & 901 EAS!	ŽEILER II PERN AVEI	NC. FUI	NERAL HO LTIMORE,	ME MD. 21231
	v 11		23a. Part 1. Enter the disease, or complications that caused the death. I shock, or heart failure. List only one cause on each line.	Do not ent	er the mode of dying	, such as cardiac or r	espiratory arres	it,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)		Intare	400			12 hours
	/Medical Examiner		Due to (or as a consequen	100 of):					
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	nce of):					
	and transi	Examiner	that initiated events c.						·····
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687	ificate g phys		d						
. Box	The law requires that the death certificate be executed ite has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregrant in the past 12 months? 1 ☐ Yes 2 Sino 0 ☐ Unknown	eath 3	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
P.0	that the de ned by the a detached f	Phy	9 ☐ Unknown  Part II. Other significant conditions contributing to death but not resulting	ing in the u	nderlying cause give	o in Part I	23e Did toba	icco use contribute to	the cause of death?
Records,	n requires that been signed should be de	ted by	Takin still significant control of the same state of the same stat	- I I I I I I I I I I I I I I I I I I I	ndonying dagge gire			2 □ No 3 □ Pr	
Secc.	has be	Completed					24a. Was an autopsy performe	prior to o	topsy findings available completion of cause of
Vital F	ician: The I certificate ha rector, page	e Col	25. Was case referred to medical			26. Place of Death (0	1 ☐ Yes 2	ZNo 1 ☐ Yes	2 No
$\leq$	N S ID	To B	examiner?	3/Outpatier	nt 3 DOA Othe	r		ce 6 □Other (Spe	cify)
n of	iding Phye th. : After this funeral di		27. Manner of Death 1 Datural 5 Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year)	8b. Time of Injury	Work	?	d. Describe how	r injury occurred	
Division	ter lea lor the	icati	2 Accident investigation 3 Suicide 6 Could not be	e farm et		'es 2 □No 28f	Location (Stre	eet and Number or Ru	ural Route Number
Di√	al or Attend after death Director: d in by the	Certification:	4 Homicide determined building, etc. (Specify)	o, 14/11/1 3ti	oot, ractory, office		City or Town,		,,,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	edical C	29a. Certifier (Check only one)  1 Certifying Physicien: To the best of my knowle 2 Medical Exeminer: On the basis of examination and manner stated.						
	To the To the comp	Me	29b. Signature and title of certifier		29c. License			d. Date signed (Monti	
)	1		Pollunce		KE-	1-000	n	lasch 23	1,2005
	ツ		30. Name and address of person who completed cause of death (Item 23)	3a) (Type,	Ctoset 1	5°00U Baltimoes	MADI	MANY 21	287
	Sta	te	31. Date filed (Month, Day, Year)  32. Registrar's Signature	0	e la la la la la la la la la la la la la	111111111111111111111111111111111111111	, ,, ,,,,,	111100 616	
	Registr	ar	MAR 2 5 2005	E AS	and .				

DHMH 17 Rev 1/2001

3

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 18, 2005 R. Rodriguez March 3:15 A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital Cheverly Prince George If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5, Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Aug. 25, 1942 6. Sex Birthplace (State or Foreign Country) Funeral 1**X**□M 2□F 62 Director Puerto Rico 581-74-6570 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylar nent of Health and Mental Hygiene. anti- if item 27 is marked other than "natural", or items 23a or 28e-f show ury or other traumatic event, If a Medical Examinating and inflied at 1 ☐ Yes 2 No Director MD Prince George Brentwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funerai 4011 Newton Street 20722 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 XYes 2 No White Specify: Specify: ģ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bus Driver Dept. of Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Inocencia Ramos Zacarias Rodriguez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yolanda Rodriguez/ Wife 4011 Newton Street, Brentwood, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or once. injury or ' 4 ☐ Donation 5 ☐ Other (Specify) MD National Cemetery 3/29/05 Laurel, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Fleck Funeral Home, Inc. Mossing 7601 Sandy Spring Road, Laurel, Maryland 20707 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CIERHOSIS LIVER **Physician** /Medical Due to (or as a consequence of) **Examiner** ALCOHOLIC if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) ed by the attending physician detached for use as the buria of Vital Records, P.O. Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 □ Unknown Part IJ. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? SYNDROME HELTO RENAL 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown GASTROINTESTINAL DLEEDING 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 1 ☐ Yes 2 ☐ No 2 No 1 Tes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 😿 No 1 Inpatient 2 EN/Outpatient 3 DOA 2 this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred To the Hospitel or Attending F within 24 hours after death.
To the Funeral Director: After it 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0043662 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHEVERLY MD 20185 J 3001 HOSPITAL WILLHAM DOYCE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

**ORIGINAL** 

OOHN WAYNE ROBERTS 05-01933 RKD

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of	Marylan		artment of F rtificate of				giene	05	10203
			1. Decedent's Name (First, Middle,	Last)				•		2. Date of Dea	ath Day	Year	3. Time of Death
	Physici /Medic		John Wayne Rol	perts						MARCH		005	10:40A. M
	Examir	er	4a. Facility Name (If not institution,	give street and numb	er)		4b. City, Town, o	r Location of	of Death			ty of Deat	th
			536 BETHEL ROAD 5. Social Security Number	3. Sex 7.	Age (In yrs. I	last hirthday)	CHESAPEA Il Under 1 Year			8 Date of Birt	CECIL		hplace (State or Foreign
h	Funeral Director		216-52-6919	1 M 2 □ F	54	Yrs.	Months Days	Hours	Min.	8. Date of Birt (Month, Da Aug 20	y, Year) 1950	Co	ryland
	<u> </u>		Usual Residence of Decedent										
	aryla:	_	MD Ce c	. 4.1		, Town or Lo							10d. Inside City Limits 1 ☐ Yes 2√ No
	the M	Director	10e. Street and Number		CIT	esapea	ke City				10g. Citizen of	What Co	
	With Ba or		536 Bethel Road	đ			101. Zip 0000	2191.	5				army :
	death ms 2;	Funeral	11. Marital Status	12. Was Decede		S. 13.	Was Decedent of H f Yes, specify Cubi			cify Yes or No-	- 14. Ra	ice - Ame	ncan Indian,
9	or ite	교	1 Never Married 2 Marrie	d 1 X Yes 2		į	fYes, specify Cubi 1 □ Yes 2 🕅 No			Hican, etc.)		ack, White ify: Wh	
903	ural',	d by	3 Widowed 4 Divorced	Year or Date	s: '67-	70							
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f show the Medical Exeminating Le notified at	Completed	15. Decedent's (Specify only highest	Education grade completed)		(Give	dent's Usual Occup kind of work done DO NOT use retired	during most	t of workin	g g	16b. Kind of E	3usiness/l	Industry unk
212	withi	шо	Elementary/Secondary (0-12)	College (1-4	or 5+)		mecha						
þ	be filed within 72 hours after death with the Marylar ital Hygliene. Id other than "natural", or Items 23a or 28a-1 show event, the Medical Examiner must be notified at	Be C	17. Father's Name (First, Middle, La	ast)				18. Mothe	er's Name	(First, Middle,	Maiden Suma	те)	
ylaı	2 should be filed withir and Mental Hygiene. Is marked other than eumatic event, the M	To	James Layman H	Roberts				N	Marga	ret Ela	anor Sa	wyer	
Maryland	s 1 and 2 should f Health and Men tem 27 is marke other treumatic		19a. Informant's Name/Relationshi				ng Address (Street						Zip Code)
	other tre		Ida J. Roberts/ 20a. Method of Disposition	spouse	20b. P		Bethel Ro	oad Ch		eake Ci	ty, MD 20c. Location		
Baltimore,	Pages nent of I ant: If its		1 Burial 2 Cremation			emetery, crer	natory or other plac	ce)			200. 2004.01.	Oity or	Tom, otalo
ij	permit. Pages Department of Important: If it any injury or once.		4 ☑Donation 5 ☐ Other (Special Service Line) 21. Signature of Funeral Service Line Ronal d S		/	23	Name and Addre	ss of Facilit	y 1	655.77	D 1		Q
B	permit. Departr Importa any inju		Ronald S	. Wade, by	rector	Ba	iate Anat Iltimore,	omy B MD	oard 21201	655 W.	Baltin	nore	Street
			23a. Part Enter the disease, or c shock, or heart failure. List of	omplications that cau	sed the death	. Do not ent	er the mode of dyir	ng, such as	cardiac or	respiratory ar	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		Ind	rao	ral St	atai	nh.	Journa	, L		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or	as a consequ	uence of):		03-7-					
	LAGITITIE	<u>_</u>	Sequentially list conditions,	b. — Due to (or	as a consequ	ience of):						$\rightarrow$	
	nsit	nlne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due 10 (01	as a consequ	dence on.							
Ć,	execuna and ial-tra	Examiner	that initiated events resulting in death) Last	c Due to (or	as a consequ	vence ol):							
8760,	death certificate be executed e attending physician and ad for use as the burial-transit	dlcal		d									
89 )	artifica ing ph e as th	Med	IF FEMALE:										
Вох	eath cerlific attending p	lan/Med	23b. Was decedent pregnant in the past 12 months?		n 2 ☐ Fetal	death 3	Ectopic pregnancy	1				ate of deli-	very Day Year
<u>o</u> .	at the de by the a tached t	Physicia	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊟Pregnan 9□ Unknow	tattime of den	aatn 5∟	Other (specify)						
ď.	de de	y Ph	Part II. Other significant condition	s contributing to deat	h but not resu	ulting in the u	nderlying cause giv	en in Part I.		23e. Did to	bacco use con	tribute to	the cause of death?
rds	quires in signeral uld be	ed by								1 🗆 Y	es 2 12 10	3 ☐ Pro	obably 4 Dunknown
Record	law requasi been 2 should	Completed								24a. Was a		Were au	topsy lindings available completion of cause of
$\sim$	9 7 9	Com								perfor	med?	death?	
Vital	Physicien: The this certificate ral director, pag	Be (	25. Was case referred to medical examiner?	11			lou		of Death	(Check only or	ne)		
of \	Physi this c	ပ	1 XYes 2 No	Hospital: 1 Inp		ER/Outpatien		4 LI NU					eity) SCENE
	ie lite	llon	27. Manner of Death  1 □Natural 5 □ Pending 2 □ Accident investiga		Day Year)	28b. Time of Injury	28c. Injur Wor		,	C/A/	ow injury occur	A	016
Division	or Attending after death. Director: Afte in by the fune	fica	3 uicide 6 ☐ Could no	t be 28e. Place of	Injury - At ho	me, larm, str	eet, factory, office		4	81. Location (S	treet and Num	ber or Ru	ral Route Number,
Ö	iel or Attendii s after death. sl Director: Al	Certification:	4  Homicide determin	building	, etc. ( <i>Specify</i>		DNE			Sity or Tow	Bet L	e/ /2	D 21915
	To the Hospitel or Att. within 24 hours after de To the Funerel Direct completely filled in by the	<u>ca</u>		Physician: To the be xaminer: On the basi		wledge, death	occurred at the tir			nd due to the o			
	the Phin 24 hin 24 the F	Medic	one	and manner	stated.		29c. Licens				29d. Date signe		
	Vith Cor	-	29b. Signature and title of certifler				OCME						
7			30. Name and address of person w	ho completed cause	of death (Item	23a\ /Time				I I	MARCH 1	0, 20	
			(To Alen	Well.	M	Low) (Type,	111 Pe	nn St	reet	Balti	more, N	1ary1	and 21201
			31. Date liled (Month, Day, Year)		istrar's Signat								
State Registrar MAR 2 5 2005  31. Date liled (Month, Day, Year)  MAR 2 5 2005													

DHMH 17 Rev 1/2001

			For Stata Registrar	State	e of Ma	aryland /	Depa <i>Cei</i>	artment of H	lealth ai Death	nd Mer		ene (	)05	10204
			Decedent's Name (First, Middle	, Last)							Date of Death	)		3. Time of Death
	Physicia		WILLIAM		WOLF	Ε		ROSENBE	RG		Month	22	Zoo5	7:35 PM
	/Medic Examin		4a. Facility Name (If not institution	, give street an	d number)			4b. City, Town, or	Location of			4c. Co	unty of Deat	h
	LXamiii	Ci	Sina: Hosp			more		B-	1time,	re			N/A	
	Funeral		5. Social Security Number	6. Sex	7. Age	e (In yrs. last b	irthday)	If Under 1 Year Months Days	If Under 2	4 Hrs. 8.	Date of Birth	Year)	9. Birti	hplace (State or Foreign untry)
	Director		216-16-0922	1 <b>X</b> M 2□	F	81	Yrs.	WOTHING Days	Hodis	10	719/19	23′		MD
g	2 >		Usual Residence of Decedent  10a, State 10b, County		1	10c. City, To	en or Lo	cation						10d. Inside City Limits
5	hod	٦ ا	,	/A		BALTII		oution						1 ☑ Yes 2 ☐ No
ě.	989-	Director	MD N	/ A		DALIII	TOKL	10f. Zip Code			10	o Citizen	of What Co	untry?
with	Te L			NC AVEN	nie.			21209			10	U.S.		array ?
tea	18 23	Funeral	6110 GREENSPRI			Ever in U.S.	13.1		ispanic Origi	in? (Specify	Yes or No-		Race - Ame	rican Indian,
ter d	te te	'n.	1 Never Married 2 Marr	Arme	d Forces?	io WW II		Was Decedent of H f Yes, specify Cuba	n, Mexican,	Puerto Ric	an, etc.)		Black, White	e, etc.
	0,1	by	3 ☐ Widowed 4 ☐ Divorced	If Ye	s, Give or Dates:			1 ☐ Yes 2 🛣 No	Specify:			Spe	ecify: WIT	IITE
5 5	atur ical	Completed	15. Deceden (Specify only highes	's Education	tad)	168	Deced	tent's Usual Occup	ation	of working	1	6b. Kind o	of Business/	Industry
<b>7</b> 1	e	ple	Elementary/Secondary (0-12)	1	ge (1-4or 5	+)	life. I	DO NOT use retired	)	or working		45011		
<b>1</b> 3	gien gerth	Con			4	E	NGIN	EER					ANICAL	
<b>5</b> §	its Hygiene.  Hy	Be	17. Father's Name (First, Middle,	Last)				NDEDO			irst, Middle, M	aiden Sur		COLLEN
7	and Mental Hygiene. and Mental Hygiene. is marked other than "natural", or items 23a or 28e-f show aumatic event, the Medical Evandrar must be notified at	၉	ALEXANDER					NBERG	BESS					COHEN
בי ל ה	is m		19a. Informant's Name/Relations					g Address (Street a					own, State, 2 E, MD	
, E	feelth im 27		MILDRED ROSENBE  20a. Method of Disposition	.KG / WI	FE			sition (Name of	TING A	Date			ion - City or	
	perini. Fages i and z shoud Department of Heelth and Men Importent: if tiem 27 is marke eny injury or other traumatic <u>once.</u>		1 ☐ Burial 2 💆 Cremation		from State	cemet	ery, cren	ERVICE CO			_			. Gwi, Giaio
	ntmer intent njury	-	' 4 ☐Donation 5 ☐ Other (S		1	LITEL		. Name and Addres						. INC.
Dall	Deparement of the property in		Dett VI	Cut	the		8	900 REIS	ΓERSTO	WN RO	AD - P	I KES\	/ILLE,	MD 21208
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications to	hat caused on each lin	the death. Do	not ente	er the mode of dyin	g, such as ca	ardiac or re	spiratory arre	st,		Approximate Interval Between
Р	hysician		Immediate Cause (Final disease or condition				. 1	Fibrillation	_					Onset and Death
	/Medical		resulting in death)	Du Du	e to (or as	a consequence	of):							
-	xaminer		Sequentially list conditions.	b	C	eronary	A	rtery Di	sease					
70	z ti	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	<b>D</b> u	e to (or as a	a consequence	of):	/						
CACLIT	and I-tran	Examiner	that initiated events resulting in death) Last	c	e to (or as a	a consequence	of):							
96,90	ohysicien and the burial-transit	alE			,	·	ŕ							
O de la companya de l	phys s the	dlcal		d							,	_		
Z Z Z	nding use a	Z/Me	IF FEMALE: 23b. Was decedent pregnant			of pregnancy						23d.	Date of deli	very
	in requires death certific been signed by the attending p should be detached for use as	Physiclan/Me	in the past 12 months?	4 🗆 F	regnant at	2 Fetal deat time of death		]Ectopic pregnancy ] Other (specify)					Month	Day Year
2 8	by the	hys	9 □ Unknown	9 🗆 ।	Jnknown									
S, T	pned le det		Part II. Other significant condition			_	in the ur	nderlying cause give	en in Part I.		23e. Did toba	cco use o		the cause of death?
CIUS,	an signal	ed		Siabetes	Mel	litus					1 🗌 Yes	2 🗆 N	o 3□Pro	obably 4 Junknown
) §	2 shc	ompleted by									24a. Was an autopsy		4b. Were au	topsy findings available completion of cause of
T P	ate ha	E O									perform	ed? No	death?	2□ No
clan	rtifice ctor, p	Be C	25. Was case referred to medical examiner?						26. Place o	of Death (C	heck only one	)		
veic <	nis ce direc	ToE	1 Yes 2 No	Hospital:	1 🗌 Inpatie	nt 2 ER/C	utpatien		4 🔲 Murs	sing Home	5 🗀 Resider	се 6 🗀	Other (Spec	offy)
	fter th		27. Manner of Death  1 Natural 5 Pendin		Date of Injur 'Month, Day	y Year) 28b.	Time of Injury	Worl			. Describe hov	v injury oc	curred	
Attending	or; A	catl	2 Accident investig	gation					Yes 2 N					
	after d Direct Direct in by	Certification;	4 Homicide determ	ined   208.1	puilding, etc		arm, str	eet, factory, office		281.	City or Town,		JM Der or Hu	ral Route Number,
DIVISION OF What is the law ramines that the death cartificate as a vaccined	to the Total State of the death, within 24 bother of the death, within 24 bother of the death.  To the Funarel Directors After this certificate has a completely filled in by the funeral director, page 2 s.	edical C	29a. Certifier 1 Certifyin (Check only one) 1 Medical	Examiner: On t	o the best of the basis of manner sta	examination a	ge, death nd/or inv	occurred at the tin restigation, in my o	ne, date and pinion, death	place, and occurred a	due to the cau at the time, dat	use(s) and e and pla	I manner as ce, and due	stated. to the cause(s)
T of	To th comp	Me	29b. Signature and title of certifie			29c. License	number		29	d. Date sig	gned (Month	n, Day, Year)		
				\$ =	<    <	M. O.		Δ5	9062			Marc	L 22	2005
	10		30. Name and address of person  CLad J. (+a)	who completed	cause of de	eath /Item 22a	Tuno	Drint\					215	
	Sta	te	31. Date filed (Month, Day, Year)	nsen, 11	32. Registra	ar's Signature	De	, veace	0-17	/-		212	-13	
	Registr	-	MAR 2 5 20	105	alex.	K A	DEN	Ivedere						

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 1. Decedent's Name (First, Middle, Last) Month 3 Year **Physician** 20 2005 HENRY LEON /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Facility Neme (If not institution, give street and number) Examiner BACTIMORE 3928 Flowerton Road If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 215.28.6748 Yrs 68 Jan.2,1937 Maryland Director Usual Residence of Decedent Peges 1 and 2 should be filed within 72 hours effer death with the Marylend nent of Health end Mentel Hygiene and the Hem 27 is marked other than "natural", or items 23s or 28s-f show ury or other traumatic event, it a Medical Examiner must be notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits ty∑ Yes 2 □ No Maryland N/A Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3928 Flowerton Road 21229 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Armed Forces? 1 Ness 2 1 ☐ Never Married 2 ☑ Married Specify: Black Baltimore, Maryland 21215-0020 1 ☐ Yes 2 🔀 No Specify. δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Dinkins Cleaners Presser 18. Mother's Name (First, Middle, Maiden Surneme) 17. Father's Name (First, Middle, Last) Be Thomas Sampson Bernice Bradley 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3928 Flowerton Rd Baltimore, Maryland 21229 Viola Sampson/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 3/28/05 20c. Location - City or Town, State rownsville, Maryland 20a. Method of Disposition permit. Peges 'Depertment of H Important: If ite any injury or ot 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Crownsville Vet. Cem. 4 ☐ Donation 5 ☐ Other (Specify) <sup>22. Name and Address of Facility</sup>Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, Md 21215 21. Signature of Funeral Service License urio Approximate Interval Between Onset and Death Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) months /Medical CANCER Examiner Due to (or as a consequence of) Physician/Medical Examine or Attending Physician: The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of deeth? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Probably 4 Unknown 1 ☐ Yes 2 ☐ No ģ 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? Completed 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home ★ Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending i efter death. I Director: Att 1 🗌 Yes 2 🗆 No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide To the Hospital of within 24 hours of To the Funeral D

Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

10 N. greenest Balt MD

29d. Date signed (Month, Day, Yeer)

and manner stated.

leted cause of death (Item 23e) (Type, Print)

32. Registrar's Signature

18 18 18 2

State Registrar

Medical

(Check only

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name end address of person who com-

**DHMH 16 Rev 6/95** 

		•	For State Registrar	State of N	laryland /	Department Certificate				giene 2	005	10206
	Physici /Medio Examir	al	1. Decedent's Name (First, Middle Language 1) 4a. Facility Name (If not institution 1)	Elizabeth  n, give subet and numbe	Stalle	nas .	Fewn, or Locati	2	2. Date of Dea Month	Day	Year 05 nty of Death	3. Time of Death 10:45 PM
	Funeral Director		5. Social Security Number 217-24-5671 Usual Residence of Decedent		Age (In yrs. last b	Yrs. Months	1 Year If Un Days Hou	der 24 Hrs. Irs Min.	Date of Birth (Month, Day 4 - 2(	, Year) )-26	9. Birthp	VA
	e Marylan la-f show	ctor	10a. State 10b. County	timore	10c. City, Tov	Randa Kanda	Ustown	)			1	0d. Inside City Limit  1 ☐ Yes 2 1 No
980	iges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene.  If Item 27 is marked other than "natural", or Items 23a or 28a-1 show or other traumatic event, the Madical Examiner must be notified at	by Funeral Director	10e. Street and Number  11. Marital Status  1 New Married 2 Mar  3 Widowed 4 Divorced	If Yes, Give	\$? <b>!</b> /40	13. Was Deced If Yes, spec	2(13) dent of Hispanic city Cuban, Mex				ace - Americ lack, White,	can Indian,
215-0036	within 72 ho ene. than "natur he Medical I	Completed	15. Deceder (Specify only highe Elementary/Secondary (0-12)	t's Education st grade completed)		Decedent's Usua (Give kind of wor ife. DO NOT us	rk done durina i	most of working	,	16b. Kind of	Business/Inc	dustry
21	ld be filed within lental Hygiene. ked other than ' ic event, the Ma	То Ве Соп	12+b GRADE 17. Father's Name (First, Middle, The Nive +	2 yrs	<b>.</b>	Usychiad	tric Ni	WSE other's Name (	First, Middle, Harri		nerd ame)	Pratt
Baltimore, Maryland	Pages 1 and 2 should be nent of Health and Mental ant: If Item 27 Is marked oury or other traumatic ev		19a. Informant's Name/Relations  L Q , Pet  20a. Method of Disposition  1 M Burial 2 Cremation  4 Donation 5 Other (5	3 Removal from State	20b. Place	b. Mailing Address  O45 Me of Disposition (Namery, crematory or of	radow no of		Route Numbe S Kloa		hlloto	0 Code) UNI: MD 21132 Own, State MD:
Balti	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service		- 11101		d Address of F	10,44	gun C C	Freene +	unera.	1 Snc.
	Physician /Medical		23a. Part1. Enter the disease, or shock, or heart fature. List Immediate Cause (Final disease or condition resulting in death)	a. Danc	ed the death. Do	Canco	e of dying, such	as cardiac or	respiratory ari	rest,		Approximate Interval Between Onset and Death
,160,	te be executed ysician and be burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	С	as a consequence							
P.O. Box 68	w requires that the death certificate be executed been signed by the attending physician and should be delached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		2 Fetal deat at time of death	h 3 ☐Ectopic pr 5 ☐ Other (sp					Date of delive	ery Day Year
	uires that I signed by Id be deta	by	Part II. Other significant conditi	ons contributing to death	but not resulting	in the underlying ca	ause given in P	art I.		bacco use co		ne cause of death?
al Records,	n: The law requires that the licate has been signed by th	Completed							24a. Was a autop: perfor 1 Yes	med? 2 No	prior to cor death?	psy findings available mpletion of cause of
of Vital	Physician: this certific ral director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpa	tient 2 ER/O	outpatient 3 DO	Other	lace of Death (  Nursing Home	-	ne) ence 6 🗆 O	Other (Specif)	y)
Division o	Attending r death. ector: After	Certification:	27. Manner of Death  1	not be 28e. Place of I		Time of Injury M	8c. Injury at Work? 1 ☐ Yes 2		d. Describe h  f. Location (S City or Tow	treet and Nur		I Route Number,
Q	To the Hospital or within 24 hours after To the Funeral Dirth completely filled in the	ical Cer	(Check only 2 Medical	ng Physician: To the be	st of my knowledg							
	To the I within 2.	Medical	one) 29b. Signature and title of certifie	and manner	stated.	290	License numb	) \ \	2	29d. Date sign	ned (Month,	Day, Year)
,	8		30. Name and address of person	who completed cause of	death (Item 23a)	(Type, Print)	1,01,	( I.W.	vel L	6)41	13/05	II RIL
	Sta Registr		31. Date filed (Month, Day, Year,	2005 A. Regis	strar's Signature	(Type, Print)  has Hapk	ins(ww	MICI C	wow (	Balti	more 1	mp mol

			1_ For		yland / Depa	artment of He	ealth and Mental F	_	F* 1.000		
			Registrar		Cei	rtificate of L	2. Date of	Reg. No. 4 UU	3. Time of Death		
	Physici /Media			candy	<i>'</i>		March	23 2005	- 630A M		
1	Examir	er	4a. Facility Name (If not institution, give s	street and number)		4b. City, Town, or $SYKC$	SVIIIE	4c. County of Dea	0//		
Ĺ	Funeral Director		5. Social Security Number 6. Set 434-22-5418	7. Age (I	n yrs. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min. 8. Date of (Month, May 2)	Birth 9. Bi Day, Year) 9. Bi O, 1922 LA	rthplace (State or Foreign country)		
	low at		Usual Residence of Decedent  10a. State 10b. County	1	Oc. City, Town or Lo				10d. Inside City Limits		
	the Marylar 28e-f ehow	ector	Md Carroll  10e. Street and Number		Sykesvil:	Le 10f. Zip Code		10g. Citizen of What C	1 X Yes 2 No		
	23a or	rai Dir	710 Obrecht Road			21784		USA	ountry:		
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 le marked other then "naturel", or Items 23a or 28e-1 ehow any injury or other treumatic event, the Medical Examinat must be notified at ance.	Completed by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates:		Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 ☐ No	spanic Origin? (Specify Yes or h, Mexican, Puerto Rican, etc.) Specify:	No- 14. Race - Am Black, Whi Specify: Wh	te, etc.		
Maryland 21215-0036	within 72 ho lene. then "natur ha Medical	ompieted	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occupa kind of work done do DO NOT use retired) BUPANT OWI	uring most of working	16b. Kind of Business food servi			
yland 2	should be filed and Mental Hyg marked other umatic event, I	To Be C	17. Father's Name (First, Middle, Last) George Milton Griv	vas			18. Mother's Name (First, Midd Marigoula At				
	nd 2 sho alth and 27 le ma		19a. Informant's Name/Relationship (Ty) Louis Sackandy (sor				nd Number or Rural Route Num C Dr., Ellicoti				
Baltimore,	Pages 1 a nent of Hee snt: If item ury or othe		20a. Method of Disposition 1 🖾 Burial 2 □ Cremation 3 □ R  4 □ Donation 5 □ Other (Specify)	emoval from State		sition (Name of matory or other place ide Cemete	Date ery 3-25-05	DuBois, PA	Town, State		
Balti	permit. Departn Importe any inji		21. Signature of Funeral Service License  Page Haight O	neral Home , Md 21784	& Chapel						
	Physician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	arrest,	Approximate Interval Between Onset and Death						
3760,	ate be executed hysician and he burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Let underlying Cause (Disease or injury that initiated events resulting in death) Last		-						
.O. Box 68	that the death certificate be exect by the attending physician detached for use as the buria	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of a 1 Live birth 2 C 4 Pregnant at time 9 Unknown	∃Fetal death 3 ☐	Ectopic pregnancy Other (specify)		23d. Date of de Month	livery Day Year		
Records, P.	e faw requires has been sign je 2 should be	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1									
Vital F		Be Co	25. Was case referred to medical examiner?				1 ☐ Yes 26. Place of Death (Check onl	2 No 1 □ Yes	3 2 □ No		
of	ng Phys fter this	P	1 ☐ Yes 2 ☐ No ☐ ☐ H  27. Manner of Death 1. ☐ Natural 5 ☐ Pending	ospital: 1	2 ER/Outpatien 28b. Time of Injury	28c. Injury Work	4 Nursing Home 5 He	e how injury occurred	ocify)		
Division	ten deat tor: the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (	- At home, farm, str Specify)		28f. Location	(Street and Number or R own, State)	ural Route Number,		
	To the Hospitel or Al within 24 hours after of To the Funerel Direc completely filled in by	edicai C	29a. Certifier (Check only one) 1 Certifying Phys	ician: To the best of ner: On the basis of ex and manner stated	amination and/or in	n occurred at the time vestigation, in my opi	e, date and place, and due to the time	e cause(s) and manner a e, date and place, and du	s stated. e to the cause(s)		
	To the vithin To the comple	Me	29b. Signature and title of certifier	(1/1		29c. License	58137	29d. Date signed (Mon			
	6	H	30. Name and address of person who co	mpleted ause of deat	h (Item 23a) (Type,	Print) 1	Mesturster	MD 211	5 7		
	Sta Registr	- 6	31. Date filed (MorMAR Var) 5 20	05 32. Fegistrar's	Signature	barle	, ,				

)5-01995 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Grover Sykes Sr. For Unpend Item 23a,27,28a-f per me G842,4-8-05 tas Certificate of Death Reg. No. 10208 2 Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Grover Sykes Sr. March 19, 2005 1322P. /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner N/A Sinai Hospital Baltimore 6. Sex 1 X M 2 ☐ F If Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number 219-50-5946 **Funeral** Months Days Hours NC56 Director Dec Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location Show r than "netural", or iteme 23a or 28a-f shov the Medical Examinations! be notified at MD N/ABaltimore 1X Yes 2 ☐ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21202 United States 941 Valley Street deeth v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. withIn 72 hours after 1 Never Married 2 Married Black Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 ☐ Widowed 4 ♣ Divorced à Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) e filed withIn al Hygiene. Construction Elementary/Secondary (0-12) College (1-4or 5+) Painter 8 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Heelth end Mental Hy Important: If Item 27 is marked oth any follury or other treumatic avent 2008. 17. Father's Name (First, Middle, Last) Be hristine LIVIES 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Grover Sykes Jr.-Son 6005 Booker Rd.Apt. В Baltimore, MD. 21228 MarDate 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 26 20a. Method of Disposition 1 A Burial 2 ☐ Cremation 3 ☐ Removal from State Zion Cem. 2005 Lansdowne, \* 4 ☐ Donation 5 ☐ Other (Specify) Calvin L. Williams Funeral Service, P. P.O. Box 11651 Baltimore, MD. 21229 21. Signature of Funeral Service Licenses -04 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final a Codeine Intoxication **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine sicien end s burial-transit requires that the death certificate be executed Due to (or as a consequence of): ed by the ettending physicien detached for use as the buria Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Dav in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably Yunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

Yes 2 No 24a. Was an autopsy performed Yes 2 No Division of Vital Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner's Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 No 2X ER/Outpatient 3 □ DOA 28a. Date of Injury 3-19-05 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Pt 24 hours efter death. Funerel Director: After th Certification: 27. Manner of Death unk 12:45 1 Natural 1 ☐ Yes 2 No investigation 2 Accident found' found n, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) A016 Edgersood 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At hom building, etc. (Specify) Baltimore, Maryland

City or Town, State) 4016 Edgewood Ave. 4 Homicide found in house To the Hospital within 24 hours e To the Funerel D 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number

State Registra

Mil M. TITLE JA(K 31. Date filed (Month, Day, Year) MAR 2 5 2 5 2005

Registrar's Signature

person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

30. Name and address of

OCME

111 Penn Street

March 20, 2005

Baltimore, Maryland 21201

		•	For State Registrar	State of M	Maryland	/ Departme			Mental Hy	giene	200	5 1020
The same of the sa	Physici /Medio	al	Decedent's Name (First, Middle,     DOLOCES     4a. Facility Name (If not institution,	M	Sess	•	ity_Town, or I	ocation of Deat	2. Date of De Month	Day 2/	Year ZOO.	3. Time of Death 7.50AM
	Examin Funeral Director		3.802 Pineir 5. Social Security Number 214-38-4828	god AV	e. Age (In yrs. Ia 64		Balti der 1 Year	If Under 24 Hrs Hours Min.		th ay, Year)	1940 Bu	thplace (State or Foreign punity)  Himore, MD.
	death with the Maryland ims 23e or 28e-f ehow	ector	Usual Residence of Decedent  10a. State 10b. County  10e. Street and Numbers	1/A	10c. City.	7777	Zip Code			10a Citi:	zen of What Co	10d. Inside City Limits 11 Yes 2 □ No
	iges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Madical Examiner must be notified at	Funeral Director	2802 Finew  11. Marital Status  1 Never Married 2 Marrie	12. Was Deceder Armed Force	s?	i. 13. Was De	2/	2/4 panic Origin? (S , Mexican, Puer	Specify Yes or No to Rican, etc.)	- (	14. Race - Ame Black, Whi	A , erican Indian,
21215-0036	in 72 hours after n "natural", or ite nadical Examina	Completed by F	3 Widowed 4 □ Divorced  15. Decedent's  (Specify only highest	If Yes, Give Year or Dates Education grade completed)	s:	16a. Decedent's U	work done du	Specify: tion tring most of wo	rking	16b. Kir	Specify:	/
	ld be filed within entat Hygiene. ked other than " ic event, the Mar	To Be Com	17. Father's Name (First, Middle, L	ast)  ACHOWIC	2	Hon	ne /i	NAKER 18. Mother's Na MAXI	me (First, Middle	, Maiden	Sumame)	
e, Maryland	1 and 2 shou Health and M em 27 is mar ither traumati	F :	19a. Informant's Name/Relationshi	fencil (1	Daur)	19b. Mailing Addr 2208 ace of Disposition (a	Gayla Name of	awn D	ural Route Numb	Kimo		nD, Z1227
Baltimore	permit. Pages Department of Important: If it any injury or c		1 Burial 2 Cremation 3 4 Donation 5 Other (Sp. 21. Signature of Funeral Service Line)	ecify)	Eva.	netery, crematory of 1998 1998 1998 1998 1998 1998 1998 199	and Address	PEL 3-3	14-05.	Fun	ocest eral+	HII MD. Gemation CH
	Physician		23a. Per 1. Entey the disease, or commodiate Cause (Final disease or condition resulting in death)	omplications that cause on each		Do not enter the n	node of dying	nck for, such as cardia	ç or respiratory a	0 67 / C:	in, pr	Approximate Interval Between Onset and Death
3760,	Medical Examiner  bhysicien and sthe burial-transit	Ilcal Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or a	as a conseque	ence of):						
.O. Box 68	death certif e attending ad for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		2 Fetal of time of dea	death 3□Ectopi	c pregnancy (specify)			2	23d. Date of de Month	livery Day Year
Records, P.	v requires that the been signed by th should be detache	ρ	Part II. Other significant condition	s contributing to death	n but not resul	iting in the underlyin	g cause give	n in Part I.		tobacco u Yes 2[		o the cause of death?
Vital Rec	F at C 1□ Yes 2½No 1□ Yes									utopsy findings available completion of cause of		
of	ing Phys 7. After this funeral dis	မ	examiner?  1 Yes 2 1 10  27. Manny of Death  1 Yeatural 5 Pending 2 Accident investigs	and the second second		Proutpatient 3 28b. Time of Injury	DOA Other	n 4 □ Nursing I	dome 5 Res 28d. Describe	dence 6		ocity)
Division	To the Hospital or Attend within 24 hours after death To the Funeral Diractor: completely filled in by the	i Certification;	3 Suicide 4 Homicide 6 Could no determin	286. Place of	etc."(Specify)				City or To	w⊓, State,	)	ural Route Number,
	n 24 hc he Fun pletely	edical		xaminer: On the basis and manner	of examination							
and manner stated  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day  30 Name and address of person who completed cause of death (Item 23a) (Type, Print)  Share C. Durso, MD 550 Hopkins Byview Circle Baltimore, MD 21224  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature										,		
	10		SAMULIC. DUR	so, MV) 55	of death (Item	23a) (Type, Print)	new Cir	de Ba	1timore,	MD	218	224
	Sta Registi		31. Date filed (Month, Day, Year)	2005 32 degi	strar's Signat	19 Speed	1					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** STALLINGS HARRY LAIRD 19, 2005 March 3:18P /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Locetion of Death Examiner 4c. County of Death Baltimore N/A Future Care Homewood If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) August 13, 1925 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Days 1√M 2□ F Mary land Yrs. 79 219-22-2278 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-1 show any Injury or other traumatic event, the Medical Examination. 10a. State 10b. County 10c. City, Town or Locetion 10d. Inside City Limits XIXXYes 2□No Director Maryland N/A Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1523 Bolton Street 21217 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? X X Yes 2 □ No WW I If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 X Never Married 2 ☐ Married WWII 1 ☐ Yes 2 X No Specify: White Specify: ۾ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Electrical Engineer Federal Government 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Naomi Whitelock Harry Bastible Stallings ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Charles L Sponseller 1523 Bolton Street Baltimore, Maryland 21217 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X remation 3 ☐ Removal from State GreenMount Crematory 3/22/05 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Mitchell-Wiedefeld Funeral Home Inc. 6500 York Road Baltimore Maryland 21212 enakis 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only, one cause on each line. Approximate Interval Between Onset end Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) Examiner share sever deserve Examine ate has been signed by the attending physician end page 2 should be deteched for use es the buriel-transit certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as e consequence of): resulting in death) Last To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the atten completely filled in by the funeral director, page 2 should be deteched for u Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the ceuse of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ Completed 24b. Were eutopsy findings available prior to completion of ceuse of death? 24a. Was en autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 28a. Date of Injury (Month, Dey Yeer) 27. Menner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: 1 Naturel 5 Pending 2 □ No 2 Accident investigation 1 Tyes 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 I Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) and menner as steted.

2 Medical Examiner: On the basis of examination end/or Investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Yeer) 0 completed cause of death (Item 23a) (Type, Print) 30. Name end add/A len 21208 Cona 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

**DHMH 16 Rev 6/95** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician Month Year 4:05 Ρм Theodore Lewis Samek March 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Brightwood Center Lutherville Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 1∭2 M 2 ☐ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 90 061-07-0859 September 8,1914 Director New York Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits alth and Mental Hygiene. 127 Ie marked other than "natural", or items 23a or 28a-f ehow er traumatic event, tra Meulcal Exarter traumatic ercelling at Maryland N/A**Baltimore** 1XXYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21210 116 D Cross Keys Rd. United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XX yes 2 □ No If Yes, Give Year or Dates: WW II 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: ģ 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) sales representative textile company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be August Henry Samek Sadie Lobel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 116 D Cross Keys Rd. Baltimore, MD 21210 Agnes Samek/wife permit. Pages 1 and Department of Healt Important: If item 2 any injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State

'4 ☐ Donation 5 ☐ Other (Specify) Greenmount crematory Mar. 23,2005 Baltimore, Maryland <sup>22</sup>, Name and Address of Facility
Mitchell—Wiedefeld Funeral Home, Inc.
4500 York Rd Raltimore, MD 21212 21. Signature of Funeral Service Licenses When O 10 Wellel 23a. Port. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, enock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician aspiration Due to for as a consequence of): /Medical Examiner Parkinson's Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and is the burial-transit The law requires that the death certificate be executed Dementio Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical attending p for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Atheroseleratio cardiovascular 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No P 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: After I 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after deat To the Funeral Director: 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier H 53088 March 22, 2005 n 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 222 West Coldspring Lane Baltimore Maryland 21210 Gold D.G. Craid #32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of M	laryland		artmen rtificate				F	Reg. No.	200	5	0212
	Physici	20	Decedent's Name (First, Middle,	Last)							<ol><li>Date of Dea Month</li></ol>	ath Day	Yea	r	of Death
	Physici /Medic		BARBARA	MARY HIC	CKS	TUCKE	3				MAR	19	2005	6:4	2 <sup>1</sup> M
	Examin		4a. Facility Name (If not institution, g	give street and number	7)		4b. City,	Town, or	Location of	Death		4c. (	County of De	ath	
			NATIONAL NAVA	AL MEDICAL				3ETHI					ONTGOM	ÆRY	
	Funeral			. Sex 7. A 1 □ M 2 X F	ge (In yrs. la		If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birtl (Month, Day	h y, Yea <i>r</i> )		Birthplace (Star Country)	
	Director		555-26-0683	10 M 201F	81	Yrs.					July 2	7, 19	923 C	alifor	nia
	pu 💌		Usual Residence of Decedent  10a, State 10b, County		10c City	, Town or Lo	cation							10d Incide	City Limits
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	Ba-f	Directo	Virginia Rockbr	idge	Lex	kingto									- X
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	ath v	Funeral	61 Ruckaway Ridg					+450					S.A.		
	tems tems	nue	11. Marital Status	12. Was Deceder Armed Forces	?	S. 13.	Was Deced If Yes, spec	lent of Hi of Cuba	spanic Orig n, Mexican,	in? (Spec Puerto P	cify Yes or No- lican, etc.)	.   1	4. Race - Ar Black, Wi	nerican Indian hite, etc.	•
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21215-0036	72 hours after death with the Maryland natural', or items 23a or 28a-1 show iteal Exantrat must be notified at	q p	3 Widowed 4 Divorced	Year or Dates	:	160 D	d= -#- 11	10	41			101-161-			
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and	ntal led ol	Be	John Norris Hic									- Maraon e	Jamamo,		
Maryland	should nd Men marke umatic	To				10h Maili		/Ctmata			unning	- Cibe or	Tour State	Zin Coda)	
Mai	12 st h and 7 is n traur		19a. Informant's Name/Relationship	Section of the sectio	use)	1					Route Numbe				
	l and lealth m 27 her ti		Albert Sidney 3	onnston Tu		Jr. Clace of Dispo			ay Kid		Lexing			or Town, State	
0	ges 1 If ite or ot		1 X Burial 2 ☐ Cremation 3	☐Removal from Stat		emetery, crei	natory or o	ther plac	e)			200. LO	sation - City	or rown, State	1
Ë	men ment: tent:		`4 ☐ Donation 5 ☐ Other (Spe		Sto	newa11				- 414	9/05		ington	, VA	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Interportent: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic avant, it is Medical Examinational Department and size.		21. Signature of Funeral Service Li-	censee		22	Name an Harri	d Addres	s of Facility Funer	al H	ome & (	Crema	atory		
ш	205 3		( )ennis	Gulm	con	-					exingto			50	
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that cause by one cause on each	ed the death line.	. Do not ent	er the mod	e of dying	g, such as c	ardiac or	respiratory ar	rest,		Approxir	Between
	Pnysician		Immediate Cause (Final disease or condition		ENDO	CARDI'	rts							Onset at	nd Death
	/Medical		resulting in death)	Due to (or a	s a consequ		110							_	
	Examiner		Coguantially list conditions	b											
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or a	s a consequ	ience of):									
	cutec	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	с											
ó	be executed ician and burial-transit	EX	resulting in death) Last	Due to (or a	s a consequ	ience of):									
8760,	e ys	icai	100	d											
9	leath certificate attending phys I for use as the			48"											
Вох	h cer andir use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			∃Ectopic pr	eanancy.				2	3d. Date of c	-	
	0 0 0	lcia	in the past 12 months? 1 ☐ Yes 2 ☐ XNo	4□Pregnant			Other (sp						Month	Day	Year
0.	by the detached	hys	9 Unknown	9□Unknown											
σ,	requires that the een signed by th rould be detache	ру Р	Part II. Other significent condition	s contributing to death	but not resu	ulting in the u	nderlying ca	ause give	n in Part I.		23e. Did to	bacco us	se contribute	to the cause	of death?
Ď	w require been sig should b	pa									1 □ Y	es 2	No 3□	Probably 4	□Unknown
ecords,	> 0 to	Completed									24a. Was		24b. Were	autopsy findin	gs available
$\alpha$	The lav	mo									autop	rmed?	prior to death		of cause of
Vital	ician: Th certificate ector, pag	e C	25. Was case referred to medical						26 Place	of Death	(Check only of	2 <b>X</b> No		95 Z   NO	
5		00	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 □ Kpa	tient 2 🗆 I	ER/Outpatier	nt 3 🗆 DO	Othe	\P		ne 5 ☐ Resid		□Other (St	paciful.	
of		To :	27. Manner of Death	28a. Date of In	jury	28b. Time o		8c. Injury			8d. Describe h			Decity)	
O	iding Ph th. : After th funeral	tion	1 X Natural 5 ☐ Pending 2 ☐ Accident investiga	(Month, E	ay Year)	Injury	м		<br Yes 2 □ N	10					
Division	Attending r death. actor: After y the fune	fica	3 ☐ Suicide 6 ☐ Could no	ad 286. Place of I	njury - At ho	me, farm, st	reet, factory	, office		2	8f. Location (S		Number or	Rural Route N	lumber,
Ö	after Dire	Certification:	4 Homicide	building,	etc. (Specify	')					City or Tow	m, State)			
	Hospital		29a. Certifier 1 🗆 🕊 ertifying	Physician: To the be	at of my know	wledge, deat	h occurred	at the tim	ne, date and	d place, a	nd due to the o	cause(s)	and manner	as stated.	
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical	(Check only 2 Medical Ex	ceminer: On the basis and manner	of examinat	ion and/or in	vestigation,	, in my or	oinion, death	h occurre	d at the time,	date and	place, and d	ue to the caus	Θ(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier				290	. License	number			29d. Date	signed (Mo	nth, Day, Yea	r)
	F 5 F 0		144		^		C	1012	23518	(VA)		11.	al a	21 20	06
	10		20 Name and a 1			232\ (T				, NAV	AL MED				ر-
	9	-	30. Name and address person w		MC US		rrutt)				20889-				
		10		32. Regis	trar's Signat	ture		בוט					-		
	Sta Regist		31. Date fill AVR 11/2 35. 7200;	Bloom	B.	Speck									

			1 - For State Registrar	State of Maryla		artment of H			4000	102	13
	Physici	an	Decedent's Name (First, Middle, La	ist)			<i>-</i>	2. Date of Death	Day Year	3. Time of	Death
	Physici /Medi		Clara Flanders			Thomas MARCH 12 2005				5 4:24	FAM
	Examir	ner	4a. Facility Name (If not institution, give	RITAN HOST	DITAL.	4b. City, Town, or	Location of Death		4c. County of De.	ath A	
7	Funeral		5. Social Security Number 6. 9	Sex 7. Age (In yr	s. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Bi	irthplace (State or Country)	r Foreign
	Director			1□ M 2/CMF 92	Yrs.	Months Days	Hours Min.	(Month, Day, ) 01 14	13	GA	
036	land	tor	Usual Residence of Decedent  10a. State 10b. County	10c. /	City, Town or Lo	cation				10d. Inside Cit	v Limits
	Mary In sh		MD NA		Baltim	ore				1 ∑ Yes	•
	or 28;	Director	10e. Street and Number			10f. Zip Code		100	J. Citizen of What C	Country?	
	72 hours after death with the Maryland Insturat', or tlems 23e or 28a-f show dical Examinat must be redified at	Funeral [	1123 Springfi				239		U.S.A		
	ter de Items		11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 📉 No	U.S. 13.	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh		
	urs af	by	3   Widowed 4 □ Divorced	If Yes, Give Year or Dates:		I□Yes 2√2 No	Specify:		Specify:	Black	
5-0	72 ho natur	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Deced	lent's Usual Occupa kind of work done of	ation	ing 16	6b. Kind of Busines:		
Maryland 21215-0036	within iene. than "		Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	)	9			
<b>d</b> 2	filled Hygi ther		12th grade 17. Father's Name (First, Middle, Last	na ")	НО	memaker	18. Mother's Nam	e (First, Middle, Ma	Hous	se	
lan	should be nd Mental marked o	To Be	Leonard Fland	ers			Mary G		,		
lary	s 1 and 2 should f Health and Men itam 27 is marke other traumatic		19a. Informant's Name/Relationship (	(Type, Print)			and Number or Rur	al Route Number, (	City or Town, State,		
	1 and 2 Health lam 27 i		Theodosia P. D							-	2908
Baltimore,			20a. Method of Disposition  1 Burial 2 Cremation 3	Removal from State		natory or other place	θ)		c. Location - City o		
Ħ	그 문 원 등		'4 □Donation 5 □ Other (Special 21. □ unature of Funeral Service Like	. 1				5-2005 L	aurel, Md		
Ba	Depa Impo any ii		AN BY		M	Name and Address arch F/I 300 Waba	H West	. Baltin	nore, Md	2121	5
	beath certificate be executed  Wedical  Wedical  Tor use as the burial-transit	dicai Examiner	23a. Part1. Enter the disease, or conshock, or heart failure. List only	plications that caused the de						Approximate Interval Betw	
H			Immediate Cause (Final disease or condition	ASCV	0					Onset and D	eath
			resulting in death)	Due to (or as a conse	equence of):					01-100	0070
			Sequentially list conditions,	b. Due to (or as a conse	equence of):						-
1-1:			if any, leading to immediate cause. Enter Underlying that initiated events								
oʻ			resulting in death) Last Due to (or as a consequence of):								
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9		o o	IF FEMALE:	23c. If yes, outcome of pregi	nancu				1		
Вох	death certifi e attending d for use as	edical Certification; To Be Completed by Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 □ Fe	tal death 3 □	Ectopic pregnancy Other (specify)			23d. Date of de Month		ear
0			1 ☐ Yes 2 ☑ ¶o 9 ☐ Unknown	9□ Unknown							
S, D	res tha igned be det		Part II. Other significant conditions of		esulting in the ur	derlying cause give	n in Part I.	23e. Did tobac	cco use contribute t	o the cause of de	ath?
ord	The law requi ate has been s page 2 should		COLON CAI	UCER				1 🗆 Yes	2 □ No 3 □ P	robably 4 Dor	iknown
Vital Records,								24a. Was an autopsy	prior to	utopsy findings a completion of cal	vailable use of
alF			05 W							s 2 No	
Ž			25. Was case referred to medical examiner? 1 □ Yes 2 XNo	Hospital: 1 ☐ Inpatient 2	ER/Outpatien	3□ DOA Othe	r	(Check only one)	e 6 □Other (Spe	if-ı)	
οl	To tha Hospital or Attending Phys within 24 hours after death. To tha Funaral Diractor: After this completely filled in by the funeral di		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at	28d. Describe how		cny)	
Division			2 Accident investigation	n	,		es 2□No				
			3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, stre cify)	et, factory, office		28f. Location (Stree City or Town, S	et and Number or R State)	ural Route Numb	9 <i>r</i> ,
			29a. Certifier  12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
			(Check only 2 Medical Exar	niner: On the basis of examir and manner stated.	nation and/or inv	estigation, in my op	inion, death occurr	ed at the time, date	and place, and due	e to the cause(s)	
	To ti To ti comp	Σ	29b. Signature and title of certified	2		29c. License		29d.	Date signed (Mont	th, Day, Year)	
)	Stat	ite	•	there co		D00.	18230	n	TARCH 2	2, 200	5
			30. Name and address of person who KALATHIL SH	completed cause of death (Ite	em 23a) (Type, I	Print) 5605	LOCH K	AVEN B	OULGVA	RD	0
			31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature	17/	THIMOR	B, 11141	YLAND	0/13	7
	Registr		MAD 0 E 200	5 Per A	. Som	E)					
			M 7 L 1 L 1 L 1 L 1 L 1 L 1 L 1 L 1 L 1 L	.1 W THE CONTROL OF STATE	1	-					

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month DELORES TEMPLE CAMILLA :45 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE
H I Inder 1 Year | If Under 24 Hrs. N 1 KITCHIE If Under 1 Year 8. Date of Birth (Month, Pay, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** Days Min. Months Hours 1□ M 2 🔀 F 20.4995 19 MD Director Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits of Health and Mental Hygiene. item 27 is marked other then "naturel", or Items 23e or 28a-1 shov other treumatic event, the Mcdical Examiner must be notified at BALTIMORE 1 ☐ Yes 2 No **Funeral Director** CATONSVILLE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 136 AVENUE 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. is marked other then "naturel", or Itel 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most-of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOME MAKER DOMESTIC TH GRADE NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be CHEW ANNIE TUCKER LEROY ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARSHAU AVE. BALTO. MD 136 WESLEY Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cometery, crematory or other place) 20c. Location - City or Town, State ₹ ± 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ō permit. Page Department of Importent: if any injury or once. MT-XION 03.29.05 BALTO, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
VAUGHN C. GREENE FUNERAL SERVICE
5151 BALTO. NATU PIKE. BALTO. MD ture of Fune al Service Licensee 21. Sign au 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or sear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician cancel una disease or condition resulting in death) /Medical Due to (or as a const uence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 1 ☐ Yes 2 ☐ No 4 DUnknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No page 2 autopsy performed? Yes 22 No 1 ☐ Yes Hospital or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify 1050 ICC 1 Yes 2 No Certification; To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a To the Funerel D Contriving Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certilier Medical (Check only one) To the 29b. Signature and title of certifier

Registrar

130 MI

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

E. Tso MD Richey Hospice 838 A

DSPICE 8

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NEutawSt

Balfimore MD 21201

			For State Registrar	State of Maryland	•	artment of h rtificate of			giene Reg. No. 2 ()	105	10215
*.	Physicia /Medic Examin	al	1. Decedent's Name (First, Middle, Last,  O(V) (G) (T) (E)  4a. Facility Name (If not institution, give	street and number)	1,04	4b. City, Town, o	1 .		Day 22 2 4c. County		3. Time of Death
	Funeral Director		5. Social Security Number 6. Sec. 212-36-5910	2hae) Nuss 7. Age (In yrs. 1 66	last birthday)	If Under 1 Year Months Days	If Under 24	Hrs. 8. Date of Birt Min. (Month, De 10/03		9. Birthple Country MARY	ice (State or Foreign y) LAND
Maryland	permit Pages 1 and 2 should be lied within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Department of Heatth and Mental Hygiene infraportant: If team 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other traumatic event, the Modical Examinal must be nutitied at once.	Director	Usuel Residence of Decedent  10a. State  MD  N/A		BALTI	MORE C	ГТY		10g. Citizen of W		d. Inside City Limits 1    Yes 2   No
36 sefter death with 1		by Funeral Dir	10e. Street and Number 2901 N. ROGERS  11. Marital Status 1 Never Married 2 Married	AVENUE  12. Was Decedent Ever in U. Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:		Vas Decedent of If Yes, specify Cub	tispanic Origin	n? (Specify Yes or No Puerto Ricen, etc.)	USA - 14. Rece Blac	e - America k, White, et	n Indian, ic.
N 5		Completed b	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 12TH	cation	(Give life.	dent's Usual Occu kind of work done DO NOT use retire	during most of		16b. Kind of Bu	siness/Indu	
<b>7</b>		To Be	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Meiden Sumame)  THOMAS E. FLANACAN, SR  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)							Code)	
Σξ	nt of Health a :: If Item 27 Is r or other train		CLAY TROY / SON  20a. Method of Disposition  1	20b. P	lace of Dispo emetery, crea	8 LYONS estion (Name of matory or other pla LAWN CE	ce)	DR, OWI Date /26/05	NGS MII 20c. Location - BALTIM(	City or Tow	m, State
Baltimore,	Department Important:		21. Signature of Funeral Service Licens	8. Raya	22	2. Name and Address	SERTY	HOWELL F	UNERAL VE, BAI	HOME TIMC	21207
8760, Signatural III	for Attending Prysician: The law requires that the death certific death.  Nifector: After this certificate has been signed by the attending p hire funeral director, page 2 should be detached for use as in by the funeral director, page 2.	Ilcal Examiner	23a. F anter the disease, or comp so or heart failure. List only of limes it to Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)	uence of):			Jascular.			nterval Between Onset and Death
P.O. Box 6		Physician/Med	IF FEMALE: 23b. Wes decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of do 9 ☐ Unknown	I death 3	Ectopic pregnand Other (specify)	у		23d. Dat Mor	e of deliver	y Day Year
rds, P.		þ	Part II. Other significant conditions co	ntributing to death but not res	ulting in the u	nderlying cause gr	ven in Part I.		obacco use contr Yes 2 □ No	nbute to the	
œ 3		Completed		40-86-00-1				24a. Was autor perfo 1 Yes	osy primed? c	prior to com death?	sy findings available pletion of cause of
Division of Vital		atlon; To Be	25. Was case referred to medical examiner?  1	Hospital: 1 Inpatient 2 Inpati	ER/Outpatie 28b. Time of Injury	f 28c. Inju	her: 44 Nurs			(-) 27	
Divis		Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specif	y) 		75-20-00-02	City or To			
//	the Funeral I	Medical	(Check only 2 Medical Exam	rsician: To the best of my kno iner: On the basis of examina and manner stated.	ition and/or in	vestigation, in my	opinion, death	occurred at the time,	date and place, a	and due to	the cause(s)
	8 2 ₹ 2 <i>,</i>		29b. Signature and title of certifier  Ametur M A			D	155	503	March	52	3 2005 2 MD 2/2/7
	V \	ate	30. Name and address of person who of the filed (Month, Day, Year)	ompleted cause of death (Iten UACEM) 50 32. Registrar's Signa		OLPHIA	IST	REET, B	SALTII	MOR	2/2/7
	Sta Regist	ate rar	MAR 257		B A	CO-ST.					

DHMH 17 Rev 1/2001

			1- State of Maryland / Dep. State of Maryland / Dep. Ce	artment of Health and N rtificate of Death		20115	10216		
ı	Physici	an	Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death		
	/Medic	al	WAVERLY TAYLOR  4a. Facility Neme (If not institution, give street and number)	4b. City, Town, or Location of Death	MARCH	19 2005 4c. County of Deat	1:00 PM		
	Examin	er	JOSEPH RICHEY HOSPICE	BALTIMORE CI	mv	N/A	n		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Y		hplace (State or Foreign		
п	Director		180-12-5528 1 <sup>1</sup> ∑ M 2□ F 97 Yrs.	Months Days Hours Min.	07/12/1	1907 soบี	TH CAROLIN		
	and w	Funeral Director	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Li	ocation			10d. Inside City Limits		
	Maryl f sho		MD BALTIMORE CATONS				1 □Yes 2□No		
	r 28a		10e. Street and Number	10f. Zip Code	10g	. Citizen of What Co			
	23a c		1017 COLLWOOD ROAD	21228	τ	JSA			
	r dea		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White			
36	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-f show to Medical Express or Items (et exittle) at	by Fi	1 □ Never Married 2 □ Married   1 127Yes 2 □ NoTIS 12 DMV	1 ☐ Yes 2 ▼ No Specify:		Specif BLA			
21215-0036	2 hou	Completed b	15. Decedent's Education 16a. Dece	dent's Usual Occupation	16	b. Kind of Business/			
215	hin 7. 9. 9n "n Medi		Flementary/Secondary (0-12) College (1-4or 5+)	kind of work done during most of work DO NOT use retired)	ing		,		
7	ygien ygien yar th		12TH CEME	INT FINISHER			NSTRUCTION		
and and	ges 1 and 2 should be filed within 72 hours after death with the Marylar it of Heatth and Mental Hygiene. If Itam 27 is marked other then "natural", or Items 23e or 28e-f show or other traumatic avant, Ita Medical Examatant traumatic avant, Ita Medical Examatant traumatic avant.	Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Ma	iden Sumame)			
ž	should ind Men s marke umatic	To	BENJAMIN DEVINE TAYLOR  19a. Informant's Name/Relationship (Type, Print)  19b. Maili	JANIE  ng Address (Street and Number or Run	BROWN	The or Town State 7	Tip Code)		
<u>≅</u>	and 2 s ealth an n 27 is har trau			17 COLLWOOD ROA					
Ē,	s 1 ar of Hea itam otha		20a Method of Dienosition 20b Place of Disno	eition (Name of		c. Location - City or			
E	Pages 1 and ment of Healt ant: If Itam 2 ury or othar		1X Burial 2 □ Cremation 3 □ Removal from State  *4 □ Donation 5 □ Other (Specify)  *CARRISO  *CARRISO  *CARRISO	matory of other place) RANS CEM. 3/29 N FOREST	9/05 OW	INGS MII	LLS, MD		
Baltimore, Maryland	permit. Page Department of Important: If any injury or once.		21. Signature of Superal Service Licensee				OME 21207		
	20E 2 3		Whyper o sury	600 LIBERTY HGI	HTS. AVE	, BALTIN			
H	Physician /Medical		23a. Part.: Enter the disease, or complications that caused the death. Do not en shock, or feart fillure. List only one cause on each line.				Approximate Interval Between Onset and Death		
			Immediate Cause (Final disease or condition a. Dementic of the normaling in death)	12 her type, suit	k chilet		16 years		
	Examiner								
	7 =	Examiner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):  Due to (or as a consequence of):						
	cate be executed physician and the burial-transit		cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):						
8760,	be exician sourials	E	Due to (or as a consequence of):						
687	ficate be ex physician s the buria	dical	d						
	res that the death certific igned by the attending p be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of delivery		verv		
Division of Vital Records, P.O. Box	death	sicia	in the past 12 months?  1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐	Ectopic pregnancy Other (specify)		Month	Day Year		
o O	at the	Phys	9 □ Unknown 9□ Unknown						
ŝ	ires th signed d be d	Certification; To Be Completed by I	Part II. Other significant conditions contributing to death but not resulting in the u	co use contribute to					
Ö	w requir been si should						obably 4 Onknown		
Rec	ne law nhas l				24a. Was an autopsy performed	prior to c	topsy findings available ompletion of cause of		
a	in the fiveships of Attending Projectain. The fail within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		25. Was case referred to medical	OC Place of Party	1□ Yes 2		2□ No		
>	ysicia Is cert direct		examiner?  1 Yes 2 No Hospital:  1 Inpatient 2 ER/Outpatier	0.1	n <i>(Check</i> on <i>ly</i> one) me 5□ Residenc	e 6 Other (Spec	ity) Hospiee		
0	ng Ph Iter th		27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28b. Time o		28d. Describe how		"" Trajeto		
Sio	Attendir death. ctor: Al y the fu		2 Accident investigation	M 1 Yes 2 No					
N N	or Atl	rtifi	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town, S	t and Number or Rui State)	ral Route Number,		
	Hospital or Attending I 24 hours after death. Funaral Diractor: After tely filled in by the funer	edicai Cer	29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funaral Diractor: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burral-transit		(Check only one)  2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
	To th withir To th comp	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month	. Day, Year)		
•	^		Po4-65 3inc M.D.	D 6 50 2175		3.19-05			
	17		30. Name and address of person who completed cause of death (Item 23a) (Type,	und, Randidstown. M.	לנוון פ				
	Sta Registr	_	31. Date filed (Month, Day, Year) MAR 2 5 2005	No.					

			1 - For State Registrar	State of Maryla	•	artment <i>tificate</i>				iene	n.	10	01-
	Physici		1. Decedent's Name (First, Middle, Last)	VANSANT.	JR.		-		2. Date of Deat Month	the Col	Year OS	3. Time of	Death /
	/Medio Examin		4a. Facility Name (If not institution, give s Good Samaritian	treet and number)		Ba1	wn, or Locat			4c. County	of Death		
	Funeral Director		5. Social Security Number 216-18-7969 6. Sex		rs. last birthday) 82 Yrs.	If Under 1 Months	Year If Un Days Hou	der 24 Hrs. rs Min.	8. Date of Birth June 22	, Year) 922		lace (State of Ital) Land	or Foreign
	ie Maryland Ba-f ehow Ilified at	ctor	10a. State 10b. County Maryland Dorches		City, Town or Lo East Net	w Mark						· · ·	ity Limits 2X No
	th with the 23a or 2 ust be no	Funeral Director	10e. Street and Number 5932 Heritage Rd.			10f. Zip C	ode 631		1	0g. Citizen of V U。S		ntry?	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or Items 23a or 28a-f ehow any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in Armed Forces? 1 XYes 2 No 1 If Yes, Give Year or Dates: 1	943- '	Was Deceder f Yes, specify 1 ☐ Yes 2	Cuban, Mex	tican, Puerto	ecity Yes or No- Rican, etc.)	Blac	e - Americ k, White, White		
Maryland 21215-0036	within 72 ho ene. than "netur he Medical.	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 1.2	cation completed) College (1-4or 5+)	(Give	dent's Usual kind of work DO NOT use	done during i retired)	most of worki	ing	16b. Kind of Bu	ernme		
yland 2	ould be filed Mental Hygi arked other atic event, I	To Be C	17. Father's Name (First, Middle, Last) Wilbur VanSant,	Sr.			18. M	-	e (First, Middle, F e James				
Mar	alth and 2 sho		19a. Informant's Name/Relationship (Ty) Sylvia Reid, comp						a <i>l Route Number</i> t Market		State, Zip 2163		
Baltimore,	Pages 1 ament of He ent: If item ury or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R 14 ☐ Donation 5 ☐ Other (Specify)		o. Place of Dispo cemetery, crem OUCON. 1				0-05	Baltim			
Ball	permit. Depart Import any inj		21. Signature of Funeral Service License  23a. Part 1. Enter the disease, or compli	2		1328 S	e Fune ılphur	ral Ho Sprin	me, Inc.	rbutus	, MD	212	
	Physician /Medical Examiner	her	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a cons	DINL IN sequence of):	rsm.	0.425 84	-117-5				Interval Bet Onset and I H DAYS	Death
8760,	death certificate be executed e attending physician and od for use as the burial-transit	dicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	sequence of):								
P.O. Box 6	death certifi e attending ed for use as	Completed by Physician/Me	IF FEMALE:   23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No  9 □ Unknown	3c. If yes, outcome of pre- 1 Live birth 2 F 4 Pregnant at time of 9 Unknown	etal death 3□	Ectopic preg Other (spec				23d. Dat Mor	e of delive		Year
ds, P	w requires that s been signed b should be deta	d by Pi	Part II. Other significant conditions cortive Single Degrow Degro				se given in P	art I.	23e. Did tot	eacco use conti s 2 □ No	ibute to th		death? Unknown
Recor	e la has	mpiete	PER PHENE MELLE VI	n disunge					24a. Was a autops	y ped?	rior to cor leath?	osy findings npletion of c	available ause of
/ital		Be	25. Was case referred to medical examiner?	ospitali x			-	lace of Death	1 Yes 2 1 (Check only on	7	Yes	2 LJ No	
Division of Vital Records,	To the Hospitel or Attending Physicien: within 24 hours after death.  To the Funeral Diractor: After this certific completely filled in by the funeral director.	tion: To	27. Manner of Death  Natural 5 Pending 2 Accident investigation	ospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	28b. Time of Injury		Other: 4 C Injury at Work? 1 Tes 2		me 5 □ Reside 28d. Describe ho			')	
Divis	tel or Atter rs after dea al Diractor ed in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, str ecity)	eet, factory,	office	7111	28f. Location (St. City or Town		er or Rura	l Route Num	ıber,
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	29a. Certifier Check only one) Certifying Physical Examination	sician: To the best of my liner: On the basis of examinant and manner stated.	knowledge, death ination and/or in-	n occurred at vestigation, in	the time, dat my opinion,	e and place, death occurr	and due to the ca ed at the time, da	use(s) and ma ate and place, a	nner as st and due to	ated. the cause(s	;)
}	To th withiu To th	W	29b. Signature and title of certifier  MWMM MW	W)		-	icense numb			MOLLA	1 8, 3		
_	10		30. Name and address of person who co	UT MD 5	tem 23a) (Type,	Print)	MEN	BLVD	, BAN	nurs.	MD	21230	9
	Sta Registi		31. Date filed (Month, Day, Year) MAR 2 5 2005	Registrar's Si	gnature	de							

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last, 2. Date of Death **Physician** /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not instit **Examiner** 5. Social Security Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1 □ M 2 😡 F Yrs. 73 Director 214-28-1145 1931 June 1, Maryland Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Maryland Frederick Adamstown Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 5109 Doubs Road 21710 United States death 1 Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status iii. Pages 1 and 2 should be filed within 72 hours after effinent of Health and Mental Hygiene. effant: If item 27 is marked other than "natural, or ite nijuy or other traumatic event, Ita Madical Exemite 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Classroom Teacher Elementary Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Roger Whalen Margaret Lawson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 701 Fairview Ave. Frederick, MD 21701 Linda Richardson / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State March 26, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or 5 Other (Specify) Resthaven Mem. Gardens 2005 4 Donation Frederick, Maryland 21. Signature of Fundal Service Licentee Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 23a. Part Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical WU Due to Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) The law requires that the death certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown been signed by the should be detached 23e. Did tobacco u e contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Tyes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy this certificate 1 Yes 2 No or Attending Physician: ours after death.

Ieral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only o Certification: To Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2 □ No 3 DOA 2 ER/Outpatient Inpatient Month, Day Year) er of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation Natural ccident 1 Tyes 2 No 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 T Homicide within 24 hours at To the Funeral D To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Sign and tille of certifier e of death (Item 23a) 31. Date filed (Month, Day, Year, legistrar's Signature State Registrar

DHMH 17 Rev 1/2001

	1 - For State Registrar	<u> </u>		Certificate	e of Dea			leg. No.2	105	1001
	1. Decedent's Name (First, Middle,	Last)				2	2. Date of Dea Month	th Day	Year	3. Time of Death
Physician /Medical	Ivery Lee Womack					M	íarch l			2:10A
Examiner	4a. Facility Name (If not institution,	give street and number)		4b. City,	Town, or Loca	ation of Death		4c. Cou	nty of Death	1
	Shady Grove Adve				ville_				gomery	
uneral	5. Social Security Number 262-56-3715	6. Sex   7. Ag 1 ☐ M 2 X F	ge (In yrs. last b	irthday) If Under Yrs. Months		ours Min.	Date of Birth (Month, Day	Year)	9. Birth	place (State or Forei intry)
ector	Usual Residence of Decedent		66	113.		<u> </u>	Sep. 24	, 1938	3 Alat	oama
5 tal	10a. State 10b. County		10c. City, Tov	n or Location					T	10d. Inside City Limi
any injury or other treumatic svent, the Medical Examinar must be notified at once.  To Be Completed by Funeral Director	Maryland Montgom	nerv	Pooles	vri 110						1∏XYes 2□N
Director	10e. Street and Number	icly	1100168	10f. Zip	Code			l0g. Citizen o	of What Cou	ıntry?
0 0	19313 Cissel Man	or Drive			2083	7		United	d Stat	-00
Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. Was Deced		ic Origin? (Speci exican, Puerto Ri	ty Yes or No-	14. F	Race - Amer	ican Indian,
교	1 Never Married 2 Marrie			1 Yes			can, etc.)		Black, White	, etc.
l by	3 ☐ Widowed 4 🎇 Divorced	Year or Dates:		TE Tes	ZLANO SP	өспу:		Spe	B1	ack
Completed by	15. Decedent's (Specify only highest	s Education grade completed)	168	a. Decedent's Usua (Give kind of wor life. DO NOT us	I Occupation	most of working	,	16b. Kind of	Business/I	ndustry
ם	Elementary/Secondary (0-12)	College (1-4or	5+)		se retired)	······································				
Co	12		La	borer					notive	2
Be	17. Father's Name (First, Middle, L	ast)			18. I	Mother's Name (		Maiden Sum	iame)	
2	Lorenzo Knox					Agnes B	-			
	19a. Informant's Name/Relationsh		19	b. Mailing Address	(Street and N	lumber or Rural I	Route Numbe	r, City or Tow	vn, State, Zi	ip Code)
	TTO TO THE TO TH	Son)		313 Ciss						
TO JO	20a. Method of Disposition  1 Durial 2 Cremation	3 □Removal from State		of Disposition (Nan ary, crematory or o		Dat		20c. Locatio	n - City or T	own, State
<u>.</u>	' 4 □ Donation 5 □ Other (Sp		Woodl	awn Cemet	_	3-15-			do, 0	hio
E S	21. Signature of Funeral Service L	icepeee	#cc03	21 22. Name an House	d Address of I	Facility Funeral	Servi	ces		
<u>a</u> a	Mancy 4. x	Desselle		12550 N	ebraska	a Ave.,	Toledo	, OH 4	1360/	
	23a. Pall. Ent. the crease, or conshock, or regime. List of	complications that cause only one cause on each li	d the death. Do ne.	not enter the mod	e of dying, suc	ch as cardiac or i	espiratory arr	est,		Approximate Interval Between
ian	Immediate Cal e (Final disease or condition	Pul	nonge	·v F	nbal	can				Onset and Death
al	resulting in death)	a	a consequence			15101				
er	Sequentially list conditions	1 Preu	moni	a						2 w Ks
ner =	Sequentially list conditions, if any, leading to immediate cause. Enter the desired to cause (Disease or injury that initiated events	Due to (or as	a consequence	of):						
Examiner	Cause (Disease or injury that initiated events	c. Lun	of Ma	\$5						
	resulting in death) Last	Due to (or as	a o sequence	of):						
Ical Examin		d							-	
Med	IF FEMALE:									
Physiclan/Medl	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth	of pregnancy 2 Fetal deat	h 3 ⊟Ectopic pr	egnancy				Date of deliv Month	rery Day Year
sic	1 ☐ Yes 2 ☑ No	4□Pregnant a 9□Unknown	t time of death	5 Other (sp	ecity)				WORTH	Day 16ai
P.	9 Unknown									
by	Part II. Other significant condition	is contributing to death t	out not resulting	in the underlying ca	ause given in i	Part I.				the cause of death?
_	-						1 L Y	es 2∐No	3 1 10	bably 4 Hiknov
ted							24a. Was a		b. Were aut	opsy findings availab
eted							perform	med?	death? 1 ☐ Yes	
ompleted					26.	Place of Death (				
ompleted	25. Was case referred to medical		ent 2 ER/O	utpatient 3 DO	A Other: 4	☐ Nursing Home	5 🗆 Reside	ence 6 □C	Other (Speci	ify)
completed	25. Was case referred to medical examiner? 1 □ Yes 2 □ No	Hospital: 1 Hipatio		Time - (	8c. Injury at	28	d. Describe h	ow injury occ	urred	
To Be Completed	examiner? 1 Yes 2 No  27. Manner of Death	28a. Date of Inju	iry 28b.		work?					
ilon; To Be Completed	examiner?  1 Yes 2 DHo  27. Manner of Death 1 Wartural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	iry 28b. y Year)	Injury M	Work? 1 ☐ Yes	2 No				
ilon; To Be Completed	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigs 3 Suicide 6 Could in	28a. Date of Inju (Month, Da	jury - At home, f	Injury	1 🗆 Yes		f. Location (Si	reet and Nui	mber or Rur	al Route Number,
runeral director, page 2 should	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigs 3 Suicide 6 Could no	28a. Date of Inju (Month, Da		Injury M	1 🗆 Yes		f. Location (Si City or Town	treet and Nui n, State)	mber or Rur	al Route Number,
funeral director, page 2 should	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investiga 3 Suicide 6 Could not determin  29a. Certifier 1 Certifying	28a. Date of Injunction of be ned 28e. Place of Injunction building, et	jury - At home, f ic. (Specify) of my knowledg	M M arm, street, factory	1 ☐ Yes , office at the time, da	28 Ite and place, and	City or Town	n, State) ause(s) and	manner as	stated.
ilon; To Be Completed	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investiga 3 Suicide 6 Could not determin  29a. Certifier 1 Certifying	28a. Date of Injunction ation of be ned 28e. Place of Injunction, el	jury - At home, f c. (Specify) of my knowledg if examination a	Injury M arm, street, factory ge, death occurred nd/or investigation,	1 ☐ Yes , office at the time, da in my opinion	and place, and death occurred	City or Town	ause(s) and ate and place	manner as : e, and due !	stated. to the cause(s)
runeral director, page z snould	examiner?  1 Yes 2 No  27. Manner of Death  1 Watural 5 Pending investige investige 4 Homicide 6 Could not determing (Check only 2 Medical E	28a. Date of Injunction of be 28e. Place of Injunction of Physician: To the best xaminer: On the basis of	jury - At home, f c. (Specify) of my knowledg if examination a	Injury M arm, street, factory ge, death occurred ind/or investigation,	1 ☐ Yes  , office  at the time, da in my opinion  License num	ate and place, and, death occurred	City or Town	ause(s) and ate and place	manner as a e, and due to ned (Month,	stated. to the cause(s)
ilon; To Be Completed	examiner?  1 Yes 2 No  27. Manner of Death  1 Marural 5 Pending investige investige 4 Homicide  29a. Certifier (Check only one)  1 Certifying 2 Medical E	28a. Date of Injunction of be 28e. Place of Injunction of Physician: To the best xaminer: On the basis of	jury - At home, f c. (Specify) of my knowledg if examination a	Injury M arm, street, factory ge, death occurred ind/or investigation,	1 ☐ Yes , office at the time, da in my opinion	ate and place, and, death occurred	City or Town	ause(s) and ate and place	manner as a e, and due to ned (Month,	stated. to the cause(s)
pletely filled in by the funeral director, page 2 should edical Certification; To Be Completed	examiner?  1 Yes 2 No  27. Manner of Death  1 Marural 5 Pending investige investige 4 Homicide  29a. Certifier (Check only one)  1 Certifying 2 Medical E	ation of be 28e. Place of Injudicing, el publician: To the best chamber of the building and manner st	jury - At home, f c. (Specify) of my knowledg if examination a ated.	Injury M arm, street, factory ge, death occurred and/or investigation,	1 ☐ Yes  , office  at the time, da in my opinion  License num	ate and place, and, death occurred	City or Town	ause(s) and ate and place	manner as a e, and due to ned (Month,	stated. to the cause(s)

DHMH 17 Rev 1/2001

			1 - For State	State of Marylan	d / Depa		of He	alth an		tal Hygier	ne 200	
	Physici	an	1. Decedent's Name (First, Middle, Last)			inouto	0, 5	<u>outr</u>			Day	3. Time of Death
	/Medic Examir		Stanley Paul We 4a. Facility Name (If not institution, give			4b. City, To	own, or L	ocation of D	Death	larch	4c. County of	
	Examin		Calvert Manor Hea	lthcare Cente	r		ing S				Ceci	
	Funeral Director		5. Social Security Number 6. Security 191–14–5930  Usual Residence of Decedent	7. Age (In yrs. 1)  M 2 F 83	last birthday) Yrs.	If Under 1 Months		Hours I	Min. (	Date of Birth Month, Day, Yea in 20, 1	922	9. Birthplace (State or Foreign Country) Pennsylvania
	within 72 hours after death with the Maryland ane. than 'natural', or Itams 23a or 28a-1 ahow the Medical Examble must be notified at	ctor	10a. State 10b. County MD Cecil	10c. City	y, Town or Lo	cation th Eas	t					10d. Inside City Limits 1 Tyes 2 No
	ith the	Funeral Director	10e. Street and Number			10f. Zip C				10g.	Citizen of Wh	nat Country?
	eath w	erai	40 Stites Lane	12. Was Decedent Ever in U.	S 13 1	Was Deceder		1901	2 (Specify	Ves or No-	USA 14 Bace	A American Indian,
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Itam 27 is marked othar than "natural", or Itams 23a or 28a-1 show amy injury or othar traumatic avant, the Medical Examt act must be notified at ance.	by	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	Armed Forces?  1 X Yes 2 □ No If Yes, Give Year or Dates: 42 ■		Was Decedei If Yes, specifi 1 ☐ Yes 2]		Mexican, P	uerto Rica	n, etc.)	Black,	White etc.
Maryland 21215-0036	lhin 72 ho e. en "naturi Medical I	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed)	16a, Dece	dent's Usual kind of work DO NOT use	Occupati done dui retired)	on ring most of	f working	16b.	Kind of Bus	iness/Industry
2	led will lygien har th		12	College (1-4or 5+) 5+		teac		0.11-11-11-	None (Fig		educat	
and	d be fi	o Be	17. Father's Name (First, Middle, Last)  Leon Howard Weiss:	man			1		,	st, Middle, Maid Cohen	en Sumame,	)
ary	shouli ind Me s mark umati	7	19a. Informant's Name/Relationship (Ty	rpe, Print)	19b. Mailir	ng Address (S	Street an			ute Number, Cit	y or Town, S	tate, Zip Code)
Ž	and 2 ealth a m 27 is		Edna A. Weissman/	- <del>-</del>				Nort		st, MD	21901	
Baltimore,	Pages 1 ment of Hi ant: If Ital		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ F  4 ☒ Donation 5 ☐ Other (Specify)	Removal from State	lace of Dispo emetery, crer	sition (Name matory or oth	of er place)		Date	20c.	Location - C	ity or Town, State
Balt	permit Depart Import any in		21. Signature of Fineral Service Licens Ronal d S.	M wear	Ba	altimo:	re, I	MD = 2.	1201		altimo	re Street
	Physician /Medical		23a. Part1. Enter the disease, or compleshock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.	on's I	er the mode		such as ca	rdiac or res	piratory arrest,		Approximate Interval Between Onset and Death
760,	ate be executed ysician and he burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence)  Due to (or as a consequence)								
.O. Box 68	the death certific: y the attending pl iched for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 ∐Live birth 2 ∏Fetal 4 ∏Pregnant at time of do 9 ☐ Unknown	death 3	Ectopic preg Other (spec				- Transaction	23d. Date Monti	,
ds, P	luires that n signed b	þ	Part II. Other significant conditions con	ntributing to death but not resu	ulting in the u	nderlying cau	ise given	in Part I.			ft z	oute to the cause of death?
Records,	The law requires that rate has been signed by page 2 should be deta	Completed						·-	-	24a. Was an autopsy performed'	pri de	ere autopsy findings available or to completion of cause of ath?  Yes 2 \( \) No
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Other:	1400		eck only one)	_	
ō	ding Phys h. After this funeral di	tion: To	1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient 2 ☐  28a. Date of Injury (Month, Day Yeer)	28b. Time of Injury		c. Injury a Work?	4 Nursii	28d.	5 Residence Describe how in		
Division	r Attar er dea ractor by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, str	reet, factory, o	office			ocation (Street City or Town, St.		or Rural Route Number,
	To the Hospital or At within 24 hours after or To the Funaral Dirac completely fitted in by	edicai	29a. Certifier (Check only one)  11 Certifying Phy 2 Medical Exami	sicien: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death tion and/or in	h occurred at vestigation, ir	the time, n my opir	, date and p nion, death o	olace, and o occurred at	due to the cause t the time, date a	(s) and manr ind place, an	ner as stated. Id due to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier			29c.	License r	number	1	29d. [	Date signed (	(Month, Day, Year)
,			of yours,	ムD	22a) (F ::	Deint')	15	)/9		M	wall	12005
			30. Name and address of person who co			rn U	ho s	aptak	e Hos	Mice, E	Iktou	n mg
•	Sta Regist	ate rar	31. Date filed (Month, Day, Year)  MAR 2 5 200	Slayon 5/N Registrar's Signa	ture	de				' /		

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month **Physician** Emma Elizabeth Washburn A: 2 2005 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Eldercare Catonsville Baltimore If Under 24 Hrs. 8. Date of Birth Month, Bay, Year)
Min. May 28, 1921 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 □ KF Months Days ountry) Maryland 83 Yrs. Director 217-12-9834 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 24 No Director MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 500 Bathurst Road 21228 natural', or Nerns 23a United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Peges 1 and 2 should be filed within 72 hours after or nent of Health and Mentel Hygiene. nt: If item 27 is marked other than "natural", or Hea 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: White δ Specify: 3 XWidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Printing Compnay 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Frederick Lutz 2 Emma Elizabeth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Peges 1 and 2: Department of Health a Important: If Item 27 is any injury or other tratence. Richard L. Cain 500 Bathurst Rd., catonsville, MD 21228 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State competery, crematory or other place)
Meadowridge
Memorial Park Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3-25-2005 Elkridge, MD 22. Name and Address of Facility Ambrose Funeral Home, Inc. 21. Signature of Funeral Service License6 1328 SUlphur Spring Rd., Arbutus, MD 21227 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) 5days Examiner Physician/Medical Examiner or Attanding Physician: The law requires that the death certificate be executed after deeth.

Director: After this certificate has been signed by the ettending physician end Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? funeral director, pege 2 🛱 No 1 Tyes 1 ☐ Yes 2 ☒ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No

Division of Vital Records, P.O. Box 68760,

To the Hospital of within 24 hours a To the Funeral D

Registrar

31. Date filed (Month, Day, Year) State

3 🗌 Suicide

29a. Certifier (Check only one)

4 Homicide

29b. Signature and title of certifier

MAR 2 5 2005

6 Could not be determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROVEN 20 4

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

32. Registrar's Signature

1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 7 / 31. Date filed (Month, Day, Year)
MAR 2 5 2005

30. Name and address of person

abrillech

32. Registrar's Signature

completed cause of death (Item 23a) (Type, Print)

**OCME** 

111 Penn Street

MARCH 18,2005

Baltimore, Maryland 21201

amend item#19b, perFil, G841.3/2)/05 TI
State of Maryland / Department of Health and Mental Hygiene
amend item#1, perMD, G842, 4/15/05 TI
Reg. No. 0 5 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Year Woodtord Edward 8:45 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Juseph Ritchie
5. Social Security Number 6. Sex Hospice Baltimore NIA If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, US 12. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 213.80.11d65 1**⊠**M 2□ F 40 Yrs. MD Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic avant, the Medical Examiner must be notified at Baltimore MD 1 Yes 2 □ No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ö Court 21202 Wilmon or Items 23a death 1 Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. hours after 1 Never Married 2 Married ∐Yes 2 No Yes, Give Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ If Yes, Give Year or Dates: 3 Widowed 4 Divorced natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene Important: If itam 27 is marked other than any injury or other traumatic avant the and injury or other traumatic. Elementary/Secondary (0-12) College (1-4or 5+) ionstruction abover 17 Father's Name (First, Middle, Last) NIA 18. Mother's Name (First, Middle, Maiden Sumame) Woodtord td ward 19b. Mailing Address (Street and Number or Aural Route Number, City or Town, State, Zip Code) 21202 19a. Informant's Name/Relationship (Type, Print) 1012 Wilmont Court Balto. ND 212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Methed of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 03.23.15 Randallstown Park 4 □ Donation 5 □ Other (Specify) Luna 21. Signal re of Funer Service Licensee Plame and Address of Facility
Vangun C. Greene Flineral. Services
SISNBAITIMORE NATIONAL PIKE BOUTO, MD 21729 23a. Part1. Enter the risease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CLIO BLASTOWA Priysician TUMUR 01 THE RAIS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner burial-transit Due to (or as a consequence of): attending physician Box 68760 pe Physician/Medical the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ŏ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) the Division of Vital Records, P.O. detached 9 Unknown 9 Unknown ል Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Wasan autopsy performed? 2₩No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Mether (Specify) Hospice Hospital: 2 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this Date of Injury (Month, Day Year) funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Certification: To the Hospital or Attanding 5 Pending investigation Natural death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deatl To tha Funaral Diractor: in by the 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide icai 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signature and the of certifier 29c. License number 00055532 pHY SICIAN MAD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Phin SIANCABY, MO A 6565 N. CHAPULES & SIO, BACT 32. Figistrar's Signature 31. Date filed (Month, Day, Year) State MAR 2 5 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 8Am State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Month **Physician** White MARCH Mae Dorothy /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death P. **Examiner** Baltimore Stella Maris Mercy P If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M XXF Yrs. 229-16-1635 Director 82 3/20/05 Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If itam 27 Is marked other than "natural", or Items 23a or 28a-1 ahov amy injury or other traumatic avant. It is Martical Examiting to other traumatic avant. It is Martical Examiting to other traumatic avant. It is Martical Examiting to other traumatic avant. Directo Baltimore MD NA 10e Street and Number 10f. Zin Code 2403 Chelsea Terr. 21216 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🎾 No Specify: þ 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade 4yrs+ 17. Father's Name (First, Middle, Last) Be ( Henry Copeland 19a. Informant's Name/Relationship (Type, Print) Evonne Harper-Daughter 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Parti. Enter the disease, or complications that caused the deshock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a cons Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a cons Examiner The law requires that the death certificate be executed Due to (or as a cons Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pre-1 ☐ Live birth 2 ☐ F 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 9 Unknown 4☐Pregnant at time of 9 Unknown Part II. Other significant conditions contributing to death but not or Attending Physician: Be 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 2 1 Yes 2 No Certification: To laral Diractor: After th 28a. Date of Injury (Month, Day Year 27. Manner of Death 5 Pending investigation 1 Natural 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - A building, etc. (Spe 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my k 2 Medical Examiner: On the basis of examinand manner stated. 29a, Certifier Medical

(Specify only highest gra		(Give kind of work done	during most of working	16b. Kind of Business	/industry
Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retire	d)		
12th grade	4yrs+	Teacher		Baltimor	e City
17. Father's Name (First, Middle, Last,	_		18. Mother's Name (i	First, Middle, Maiden Sumame)	
Henry Copeland	E		Mary Jar	ne Edwards	
19a. Informant's Name/Relationship (		19b. Mailing Address (Stree	and Number or Rural F	Route Number, City or Town, State, J	Zip Code)
-	Daniel Lan				- <del> </del>
Evonne Harper-		P.O. Box 11 Place of Disposition (Name of	o, welak		T Ctt-
20a. Method of Disposition 1 Description 2 □ Cremation 3 □		cometery, crematory or other pla		20c. Location - City or	rown, State
4 ☐ Donation 5 ☐ Other (Specif		Loudon Park	3/23/	04 Baltimore	, Md
21. Signature of Funeral Service Licer	isee /	22. Name and Addr	ss of Facility		
1 mille	K- Jone	March F/	H West	Baltimore, Md	21215
23a Part1 Enter the disease or com	nlications that aused the dea				Approximate
23a. Part1. Enter the disease, or com shock, or heart failure. List only	one cause on each line.	1	ng, saon as carciae or r	aspiratory arrest,	Interval Between Onset and Death
Immediate Cause (Final disease or condition	2	colon car	Ver		Onset and Death
resulting in death)	Due to (or as a conse	equence of):			
Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conse	equence of):			
f any, leading to immediate cause. Enter Underlying Cause (Disease or injury					
that initiated events resulting in death) Last	c Due to (or as a conse	remonant):			
,	Due to (or as a conse	equance or).			
	d				
F FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregu			23d. Date of del	ivery
in the past 12 months?	1☐Live birth 2☐Fei 4☐Pregnant at time of		у	Month	Day Year
1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown				
and II. Other significant conditions	contribution to don't but not re	eculting in the underlying access of	un in Dard I	22a Did tobacca use control uto to	the sauce of death?
Part II. Other significant conditions of	contributing to death but not re	suiting in the underlying cause gr	ven in Part I.	23e. Did tobacco use contribute to	
				1 ☐ Yes 2 No 3 ☐ Pr	obably 4 Unknown
				24a. Was an 24b. Were au	itopsy findings available
				autopsy prior to operformed? performed?	completion of cause of
					2 No
5. Was case referred to medical examiner?			26. Place of Death (0	Check only one)	
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 [	☐ ER/Outpatient 3☐ DOA Ott	ner: 4 🗆 Nursing Home	5 Residence 6 Other (Spe	city) NISDICE
7. Manner of Death	28a. Date of Injury	28b. Time of 28c. Inju	ry at 280	d. Describe how injury occurred	10000
1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury Wo	rk?  Yes 2 □No		
3 Suicide 6 Could not b	e Zeo Place of Injune. At	home, farm, street, factory, office	286	Location (Street and Number or Ru	iral Pauta Number
4 Homicide determined	building, etc. (Spec	cify)	201	City or Town, State)	irai riodie radiliber,
29a. Certifier 1 ☐ Certifying Ph (Check only 2 ☐ Medical Exar	ysician: To the best of my kr	nowledge, death occurred at the ti	me, date and place, and	d due to the cause(s) and manner as at the time, date and place, and due	stated.
one)	and manner stated.	attor and or investigation, in my	plinon, death occurred	at the time, date and place, and due	to the cause(s)
29b. Signature and title of certifier		29c. Licen	se number	29d. Date signed (Monti	h, Day, Year)
		1	05-631	2/7/	2005
, 04(		DH	2854	7.011	2003
0. Name and address of person who		em 23a) (Type, Print)		,	
David Rise	berg 301	ST Paul Pi	Baltino	re md. 2120	2
31. Date filed (Month, Day, Year)	2. Registrar's Sigr	nature			
MAR 2 5 200	5 Marie B	hard a			
	Judges 15	The state of the s			
		ODICINAL			
		ORIGINAL			

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

11 Yes 2 □ No

Day

20,

4c. County of Death

10g. Citizen of What Country?

Specify:

U.S.A.

Race - American Indian, Black, White, etc.

Black

Year

2005

State

Registrar

Physiciar /Medica Examiner  Funeral Director	n al -	1. Decedent's Name (First, Middle, Last)  JOSEPHINE					Reg. No.	
Examined Funeral Director				Wile	ZYNSKÍ	2. Date of De Month		3. Time of Death
Maryland f show		4a. Facility Name (If not institution, give s	orkins Hespi	4b. Cit	r Town, or Location of De or 1 Year   If Under 24 H	2	ay Year)	rthplace (State or Foreignatry)  IARYLAND
Ma - S		Usual Residence of Decedent  10a. State 10b. County	10c. City, T	own or Location				10d. Inside City Limit
1 the	Director	MD . N/A  10e. Street and Number		BALTIMO 10f. 2	RE lip Code		10g. Citizen of What C	1 X Yes 2 □ N country?
s 238	Funeral	2115 MOYER STR.  11. Marital Status  1 □ Never Married ※ Married	EET  12. Was Decedent Ever in U.S. Armed Forces?  1	If Yes, sp	21231  Redent of Hispanic Origin? Recity Cuban, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	Black, Wh	erican Indian, ite, etc.
	Completed by	3 Widowed 4 Divorced  15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	Year or Dates:	6a. Decedent's Us	sual Occupation work done during most of use retired)	working	Specify: WH	s/Industry
	Be	17. Father's Name (First, Middle, Last)		HOUSE	18. Mother's h		DOMES o, Maiden Sumame)	STIC
of shared	2	VICTOR FATTOR	oe, Print)		MARY ss (Street and Number or	Rural Route Numb	per, City or Town, State,	
es 1 and of Health I item 27 r other tu	-	WALTER WILCZYNS  20a. Method of Disposition  1 © Burial 2 □ Cremation 3 □ Re  1 Donation 5 □ Other (Specify)	emoval from State	e of Disposition (Netery, crematory of	YER STREET  ame of other place)  EMETERY 3 /	Date	ORE, MD. 2 20c. Location - City o  BALTIMORE	r Town, State
Department Important: Il any injury o		21. Signature of Funeral 85 Ace License		22 Name	and Address of Facility Y & ZEILER EASTERN A			
por icia	7	23a. Part1. Enter the disease, or complications, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cations that caused the death. It e cause on each line.  Due to (or as a consequent Due to (or as a co	Do not enter the management of				Approximate Interval Between Onset and Death IO olays
2 2	Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of death 9 □ Unknown	ath 3 Ectopic			23d. Date of de Month	elivery Day Year
been signed by should be detact	à	Part II. Other significant conditions con	tributing to death but not resultir	ng in the undertying	g cause given in Part I.		tobacco use contribute t	to the cause of death? Probably 4 Munkno
ate h	Completed					24a. Was auto perfe 1 Yes	ppsy prior to ormed? death?	utopsy findings availa completion of cause s 2 No
After this cert	ToB	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation		VOutpatient 3 (1)  Bb. Time of Injury M	Other	-	one) idence 6 Other (Spender) how injury occurred	ecify)
24 hours after death. Property filled in by the fulled in	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, street, fact	ory, office		(Street and Number or F wn, State)	Rural Route Number,
Funer Funer ely fill	edical	29a. Certifier 1 ★ Certifying Phys (Check only one)	sicien: To the best of my knowle ner: On the basis of examination and manner stated.	edge, death occurre a and/or investigation	ed at the time, date and plon, in my opinion, death o	ace, and due to the ccurred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
within 2  To the complete	M	29b. Signature and title of certifier  Aud May	2 ND		9c. License number RES – 000 BALLIMARE	0	March 2"	

DHMH 17 Rev 1/2001

amend Item#9, Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No... 1. Decadent's Name (First, Middle, Lest) 2. Date of Death 3. Time of Death **Physician** Walker Year Sarbzirz 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner Randallstown, MD Northwest Hospital Conte 5. Social Security Number 229 441230 If Under 1 Year Months Days If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Virginia 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 □ M 2 □ F Yrs. Director Usual Residence of Decedent Pages 1 end 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10b. County 10a. State 10c. City, Town or Location 7 is marked other then "natural", or items 23a or 28a-1 show traumatic event, the Medical Examiner must be notined at 10d. Inside City Limits MI Director Mills, 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: Black ð 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Lepertment of Health and Mental Hygiene.
Important: If item 27 is marked other then "ne any injury or other traumatic event energy. Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Be Blown **Blanton** nant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9708 Bon Wing Mills MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 □ Removal from State Koosevert Memorial ta 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fune of Service Licen, ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Be Completed by Physiclan/Medical Examiner The law requires that the death certificate be executed ig physician and as the buriel-transit Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last 4b,  $4|O_0|$ , 12, 14, 24a Division of Vital Records, P.O. Box 68760, nse Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the ceuse of death? 1 ☐ Yes 2 ☐ No 3 □ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy periomied? DIPT 2 X No 1 🗆 Yes 1 ☐ Yes 2 ☐ No the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA Medical Certification: To 1 Yes 21 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Phys within 24 hours after death.

To the Funerel Director: After this 28a. Date of Injury (Month, Day Year) 27. Mann of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Watural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide 29a. Certifier (Check only one) 1 🗴 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b, Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

MI)

32 Registrar's Signature

MORTHUGEST

HOSPITAL CENTRA

State Registrar 31. Date filed (Month, Day, Year)

			1 - For State Registrar	State of M	aryland / เ	Departmer Certificat			d Mental Hy	/giene 0	05	10227
	Physici /Medic	al	1. Decedent's Name (First, Middle,  NANCY  4a. Facility Name (If not institution, g	IRCINIA	WEB		Town or	Location of D	2. Date of De Month	Day	Yeer 200 5	3. Time of Death
	Examir	ier	GENESIS ELDERO  5. Social Security Number 6	CARE:Multi	ge (In yrs. last bil		, 1 YEW	Si Ohder 24		Balt:	imore	County ce (State or Foreign
	Director		212-20-8739 Usual Residence of Decedent 10a. State 10b. County	X	87				May 7,	, 1923	Mary 10d	Land  Linside City Limits
	n the Mary r 28a-f sh rodiffed	irector	Maryland Baltimo	re County		Tows	On Code			10g. Citizen of V	What Country	1 □ Yes 2 No
	be filed within 72 hours after death with the Maryland ital Hygiene.  d other than "natural", or Itams 23a or 28a-f show evant, the Medical Exam and mall to indiffice at	Funeral Director	7700 York Roa	12. Was Decedent Armed Forces?	?	13. Was Dece		204 spanic Origin n, Mexican, P	? (Specify Yes or Nuerto Rican, etc.)		USA ce - American ck, White, etc	
-0036	2 hours afte atural', or l	þ	1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's	If Yes, Give X Year or Dates:		1 Tes	al Occupa	Specify:		Specify	MITT	
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Maryland	hould be fill d Mental H narked oth natic evan	To Be	17. Father's Name (First, Middle, La Alva Arthur We 19a. Informant's Name/Relationship	bb	100	Mailing Asteleon		Ruth	Name (First, Middle  1 Cecil  Ir Rural Route Numb	Hughes		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Itams 23a or 28a-f show any injury or other traumatic event, It is Medical Exame in it intelled at angle.		Thomas A. Webb  20a. Method of Disposition 1 ♥ Burial 2 □ Cremation 3	(Bro.)	20b. Place of		bury	Road,	Baltimor Date	608 60	and 21	239
Baltimore,	permit. Pag Department Important: any injury o		* 4 ☐ Donation 5 ☐ Other (Spe 21. Signature of Funeral Service Life	Censed Lawren	Mounta	22. Name ar Mitche	nd Address	s of Facility Viedefe	ld Funera	al Home.	Inc.	Maryland
	Fnysician /Medical		Martin D Sa 23a. Part1. Enter the disease, or co shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	aT	the death. Do ine.	VTIA	(OCIC le of dying	ROAG, g, such as car	Baltimore	: Mary 18 irrest,	Ö	proximate Interval Between Inset and Death
	Examiner pu	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undarying Cause (Disease or injury that initiated events	b. Due to (or as	a consequence	of):						
38760,	icate be executed physician and s the burial-transit	cal	resulting in death) Last	Due to (or as	a consequence	of):						
P.O. Box 6	The law requires that the death certific tie has been signed by the attending p page 2 should be detached for use as i	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death	3 □Ectopic p 5 □ Other (sp				23d. Dat Mo	te of delivery inth Da	ay Year
	w requires that the de been signed by the a should be detached f	by	Part II. Other significant conditions	s contributing to death b	out not resulting i	n the underlying o	ause give	on in Part I.	14	tobacco use conti Yes 2 ☐ No		cause of death?
II Reco	The law requirate has been page 2 should	Completed							24a. Was auto perfo	opsy ormed?	prior to comp death?	y findings available letion of cause of
Division of Vital Records,	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	tion: To Be	25. Was case referred to medical examiner?  1 Yes 2 Na  27. Manner of Death 1 Natural 5 Pending investigal	Hospital: 1  Inpati	ıry 28b.	itpatient 3 DC	28c. Injury Work	r: 4 Nursir	Death (Check only ong Home 5 Resident 28d. Describe			
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l		•	For State Registrar		State of	Maryla	nd / Depa <i>Ce</i>	artmen rtificate				lental Hy	giene Reg. No	11115	10228
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	Funeral Director		5. Social Security Number 233-06-5263	6. 5	ex □M 2□F	. Age (In yr.	s. last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir Oct 2,	1962	9. Bird Co	hplace (State or Foreign
	pu		Usual Residence of Deceder 10a. State 10b. Co			100 (	City, Town or Lo	nation							10d. Inside City Limits
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	leath	era	11. Marital Status		12. Was Dece	dent Ever in	U.S. 13.	Was Deced				ecify Yes or No	)-	14. Race - Ame	ncan Indian.
39	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Itams 23e or 28e-f show any highly or other traumatic event, it a Medical Examinational by notified at ance.	Completed by Funeral Director	1 □ Never Married 2 □ 3 □ Widowed 4 □ Divo		Armed Ford 1 Tes If Yes, Give Year or Da	No No		lf Yes, spec 1 ☐ Yes		Specify:		ecify Yes or No Rican, etc.)	1	Black, Whit	e, etc.
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	/Medical		resulting in death)		Due to (c	or as a conse	equence of):	7	107						
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-4	D 15	Examiner	Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or injury	1	Due to (d	or as a conse	equence of):								
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				N	1. 11				OCME	ı			MAR	CH 19,	2005
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1. Decedent's Name (First, Middle, Last)

Edward Burgess Adams

4a. Facility Name (If not institution, give street and number)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

of Manufaced / Danastonant of Lincith d Mental Hy

4b. City, Town, or Location of Death

State	OI I	maryland /	Department	TO J	Health	and	N
			Certificate	9 01	f Death	7	

ygiene	A	Ω	ye - 10	3	/11	0	$\circ$	1
Reg. No	U	U	0	Production	U	6	6	-

Year

4c. County of Death

3. Time of Death

6:20 A. M

2. Date of Death

March 8, 2005

Physician	
/Medical	
Examiner	

**Funeral** Director r then "naturel", or items 23a or 28a-f show the Madical Examiner must be notified at It Hygiene.

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Baltimore, Maryland 21215-0036 27 is markad c and Mental item 27 i permit. Pages 1
Department of H
Importent: if ite
any injury or ott

Physician /Medical **Examiner** 

Examiner -transit burial-Completed by Physician/Medical as esn ned by the atter page 2 Be Certification: To After after death. the filled in by within 24 hours a

Hospitel or Attending Physicien: The law requires that the death certificate be executed

Box 68760.

P.O.

Records.

Division of Vital

Calvert Memorial Hospital Prince Frederick Calvert 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **X**XM 2□ F New York 133-09-4969 Usual Residence of Decedent 10a State 10b Counts 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√2 No Director Maryland Calvert Solomons 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11450 Asbury Circle, Apt. #325 20688 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes Ž☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Bayman Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Robert S. Adams Blanche Burgess ္ရ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) Estelle Edwards Adams (Wife) 11450 Asbury Circle, Apt.#325, Solomons, MD 20688 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory 3/09/05 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rausch Funeral Home, P.A. 4405 21. Signature of Funeral Service Licensee Broomes Isl. Rd., Port Republic, Maryland 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Hypoxia Due to (or as a consequence of): Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Heart Failure Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? 1 ☐ Yes **2√** No 2 XNo 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ♣ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 152 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

263 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) lendone D0060638 March 8, 2005

Registrar DHMH 17 Rev 1/2001

State

32. Registrar's Signature

110 Hospital Road, Prince Frederick, Maryland 20678

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N. Mendonca, M.D. 31. Date filed (Month, Day, Year)

Funeral Director    Director   Di	of Deeth  e Georges  9. Birthplace (State or Foreign Country)  DC  10d. Inside City Limits 1% Yes 2 No  What Country?  JSA  9. American Indian, k, White, etc.  Black  Isiness/Industry  d States ment of Labor  e)  State, Zip Code)  City or Town, State
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Director    Standard	DC  10d. Inside City Limits 12 Yes 2 No  Vhat Country?  USA  - American Indian, k, White, etc.  Black  Issiness/Industry  d States ment of Labor  e)  State, Zip Code)  City or Town, State
10a. Slate   10b. County   10c. City, Town or Location   10b. Code   10g. Citizen of Variation   10d. Slate   10d. Slate   10d. Slate   10d. Clay Code   10d. Clay Clay Code   10d. Clay Code	No Yes 2 No  What Country?  JSA  a - American Indian, k, White, etc.  Black  Isiness/Industry  d States ment of Labor e)  State, Zip Code)  City or Town, State
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1   Burial   2   Cremation   3   Removal from State   Cheltenham   Vet.   3/11/2005   Chelte	ngton, MD City or Town, State
1   Burial   2   Cremation   3   Removal from State   Cheltenham   Vet.   3/11/2005   Chelte	ngton, MD City or Town, State
1   Burial   2   Cremation   3   Removal from State   Cheltenham   Vet.   3/11/2005   Chelte	City or Town, State
1   Burial   2   Cremation   3   Removal from State   Cheltenham   Vet.   3/11/2005   Chelte	
21. Signature of Funeral Service Licensee  22. Name and Address of Facility  Raymond—Wood I  PO Box 430, Dunkirk, MD 207!  23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading or unimediate cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence	ennam, MD
Physician /Medical Examiner  Per graphs Add Supplies or conditions or south for the mode of the season of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  FFEMALE:  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Due to (or as a consequence of):  Due	
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death)  List only one cause on each line.  Due to (or as a consequence of):	7.H., P.A. 54
Immediate Cause (Final disease or condition resulting in death)   Immediate Cause (Final disease or condition resulting in death)	Approximate Interval Between
The dical Examiner   Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death)   Due to (or as a consequence of):    Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   Due to (or as a consequence of):    Due to (or as a consequence of):	Onset and Death
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E Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	
IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Dat 1	
IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Dat 1	
FFEMALE: 23d. Date   1   23d. Date   23d	
230. Was decedent pregnant in the past 12 months? In the past 12 mon	e of delinent
9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  239. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.	•
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	
	ibute to the cause of death?
1 Yes 2 No	3 Probably 4 Unknown
1   Yes 2   No  1   Yes 2   No  24a. Was an autopsy performs autopsy perfo	Vere autopsy findings available
autopsy performed 1 Yes 2 7 No	prior to completion of cause of leath?
25. Was case referred to medical examiner?  Hospital:  Other	1105 20110
examiner?    Comparison   Compa	ar (Specify)
27. Many of Death  28a. Date of Injury  28b. Time of Injury at Work?  28d. Describe how injury occurr (Month, Day Year)	be
1 Matural 5 Pending (Month, Day Year) Injury Work? 2 □ Accident investigation M 1 □ Yes 2 □ No	
28a. Date of Injury  28b. Time of Injury  28c. Injury at Work?  1 Natural  2 Accident  3 Suicide  4 Homicide  28b. Place of Injury  28c. Injury at Work?  M 1 Yes 2 No  28c. Injury at Work?  1 Yes 2 No  28c. Digury at Work?  28c. Digury at Work?  28c. Digury  M 1 Yes 2 No  28c. Digury at Work?  28d. Describe how injury occurre  City or Town, State)	er or Rural Route Number,
Ser in the series of the serie	
autopsy performed?    Comparison of the property of the proper	
# 29b. Signatura and title of certifier 29d. Date signed	(Month, Day, Year)
D51520 03-04	-7005
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	~ ,
Bahram Phisdad, M.D. 1328 Southern Ave., S.E.#310, Washi	
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	ngton, DC
Registrar MAR 0 7 2005 Alasa & Aparles	ngton, DC

DHMH 17 Rev 1/2001

			For State Registrar	State o	f Marylar		artment of rtificate o		ind Ment		ene g. No	05	10231
	Physici /Medic	an	1. Decedent's Name (First, Middle Barbara Rose Ar	nderson					Man	ate of Death Nonth	Day 1	Year 2005	3. Time of Death
	Examin		4a. Facility Name (If not institution Union Hospital				4b. City, Town Elkton	L	f Death		4c. Coun	ty of Death	
	Funeral Director		5. Social Security Number 234 14 2507	6. Sex 1 ☐ M 2 <b>X</b> ☐ F	7. Age (In yrs.	last birthday) 86 Yrs.	Months Day		Min. (A	ate of Birth Month, Day, c. 25,	<sup>Year)</sup> 1918	Cour	place (State or Foreign ntry) Virginia
	Maryland -f ahow	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Cecil			th Eas						1	0d. Inside City Limits 1 ☐ Yes 2√ No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other traumatic event, the Modical Exactil at must be indiffed at once.	eral Director	10e. Street and Number  328 Mechanics V  11. Marital Status				10f. Zip Code		in? (Specify )	U	g. Citizen of		2s
900	ours after d	Completed by Funeral	1 □ Never Married 2 □ Marri 3 ☑ Widowed 4 □ Divorced	Armed Fo	rces? 2 X No /e		Was Decedent of If Yes, specify Ci		, Puerto Ricar		Spec	ack, White, ify: WI	etc. nite
21215-0036	within 72 h ene. than "natu ne Medical	mpiete	15. Decedent (Specify only highes Elementary/Secondary (0-12)	's Education it grade completed) College (	I-4or 5+)	(Give	dent's Usual Occ kind of work dor DO NOT use reti	ne during most red)		1	6b. Kind of	Business/In	
	should be filed on Mental Hygie marked other Imatic event,	To Be Co	17. Father's Name (First, Middle, George Michael			ASSE	ubiy Lin	18. Mothe	r's Name <i>(Fir</i> s ara The		faiden Suma	ame)	Tilg
Maryland	d 2 shou th and M ?7 is mar traumati		19a. Informant's Name/Relationsl Laura Simpson/G	nip (Type, Print)	ntor		ng Address <i>(Stre</i>	et and Numbe	r or Rural Rou	ite Number,	City or Tow	n, State, Zip	Code)
Baltimore,	Pages 1 and nent of Health int: If item 27 iry or other th	1	20a. Method of Disposition  13 Burial 2 Cremation  4 Donaton 5 Other(S)	3 □Removal from		Place of Disporter East	osition (Name of matory or other p St Metho emetery	dist M	Date 2005	Delaw 2	Oc. Location	- City or To	own, State
Balti	permit. Departri Importa any inju		21. Sign ruje 15 h day Service			1:	2. Name and Add	ress of Facilit	<sup>y</sup> Croucl Street	n Fune North	ral Ho East	ome	land 21901
	Physician /Medical Examiner		23a. Part 1. Enter the disease of shock, or heart failure. List immediate Cause (Final disease or condition resulting in death)	a. Due to	oach line. OCALD い (or as a conseq	AL Inquence of):	FARCTI	مر	cardiac or resp	piratory arre	st,		Approximate Interval Between Onset and Death Hours
8760,	rate be executed only sician and the burial-transit	icai Examiner	Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to	or as a cons	uence of:							YEAKS
.O. Box 68	law requires that the death certifica as been signed by the attending pr 2 should be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 ☐ Live t	tcome of pregna birth 2 Peta nant at time of cown	al death 3	□Ectopic pregnal □ Other (specify)					ate of deliver	ery Day Year
۵.	w requires that been signed b should be deta	þ	Part II. Other significent condition OSTEO ALTHA		eath but not res	ulting in the u	inderlying cause	given in Part I.		23e. Did tob 1 ☐ Ye		-	ne cause of death?
Il Records,	The ate h page	Completed								24a. Was an autopsy perform Yes 2	/	were auto prior to co death? 1 ☐ Yes	psy findings available mpletion of cause of
Vital	yaician: The is certificate ha director, page	To Be	25. Was case referred to medical examiner? 1	Hospital	Inpatient 2	] ER/Outpatie	nt 3 DOA	Teh on	of Death (Chersing Home			ther (Specif	y)
ion of	ding Ph n. After thi funeral		27. Manner of Death  1 Natural 5 Pendin 2 Accident investig	g 28a. Date (Mon		28b. Time of Injury	V	jury at Vork? □ Yes 2 □ I		Describe ho	w injury occu	urred	
Division	in Eight	Certification:	3 Suicide 6 Could I 4 Homicide determ	ined 288. Place	of Injury - At h ing, etc. (Speci		reet, factory, offic	ee		ocation (Str City or Town,		nber or Rura	d Route Number,
	e Hospital	edical		g Physicien: To the Exeminer: On the b and man									
	To the within 2 To the complete	M	29b. Signature and title of certifier	r				nse number			NAKCH		
	10		30. Name and address of person				Print)	•				. 170	
	Sta	ite	David Gar-e1 3 31. Date filed (Month, Day, Year)		rth Str Registrar's Signa		ite #3 ]	Elkton,	Maryl	and 2.	1921		
	Regist		MAR 1	0 2005	Land on a	K	hasti)						

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Maryla		artment of H		ental Hygie	2000	10232
			Decedent's Name (First, Middle, L.	.ast)	-			2. Date of Death	No.	3. Time of Death
Щ	Physic		Tohn T	7				Month	Day Yeer	7.44
	/Medi Examir		John I  4a. Fecility Name (If not institution, or		strong	4b. City. Town, or	Location of Death	March	10 2005 4c. County of Death	
1	LXaiiiii	iei	189 Parkside							
Н	Funeral				s. last birthday)	Earlev If Under 1 Year	If Under 24 Hrs.	3. Date of Birth	Cecil 9. Bint	place (State or Foreign
	Director		198-30-7964	X□M 2□F 66	Yrs.	Months Days	Hours Min.	(Month, Day, Ye	ear) Cou	dia, PA
-			Usual Residence of Decedent					60 72 I	939   Me	IId, PA
	ylen How		10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits
	Ma	Director	MD Cecil	E	arlevi	11e				1 ☐ Yes Ž\D\No
	7 28 L	<u>ĕ</u>	10e. Street and Number		<u> </u>	10f. Zip Code		10g.	Citizen of What Cou	intry?
	h wit		189 Parkside D	rive		21	919		United S	States
	de st	19	11. Marital Status	12. Was Decedent Ever in	U.S. 13.		ispanic Origin? (Spec n, Mexican, Puerto R		14. Race - Amer	can Indian,
9	s 1 and 2 should be filad within 72 hours efter desth with the Marylend f Health end Mentel Hydens. Item 27 fe markad other than "neturel", or items 23a or 28s-f show other traumatic event, the Medical Examinar must be notified at	by Funeral	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ∑Yes 2 ☐ No If Yes, Give				ican, etc.)	Black, White	, etc.
8	an and	ğ	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		I□Yes 2½ No	Specify:		Specify:	Vhite
21215-0036	72 hg	Completed	15. Decedent's (Specify only highest of		16a. Deced	lent's Usual Occupa	ation during most of working	16b	. Kind of Business/Ir	ndustry
2	thin thin	횰	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	OO NOT use retired	) )		ele	
2	filled will Hygien other th	5	12		Eng	ineer			ommunica	ations
B	e filed el Hygie t other vent,	Be	17. Father's Name (First, Middle, Las	st)	_		18. Mother's Name (			
/a	ould be Mentel Markad o	2	William John A	rmstrong			Helen	Haves		
Maryland	end l		19a. Informant's Name/Relationship	(Type, Print)	19b. Mailin	g Address (Street a	and Number or Rural		ty or Town, State, Zi	Code)
	alth alth		Louise Armstro	nq	189	Parksid	e Drive,	Earlev	ille, MI	21919
ore.	es 1 and 2 should be of Health end Mentel I Item 27 te markad c r other traumatic eve		20a. Method of Disposition		Place of Dispo	sition (Name of natory or other place	Da		Location - City or T	
Ĕ	Peges nent of ant: If Its ary or o		1 ☐ Burial 2 ☐ Cremation 3  `4 ☐ Donation 5 ☐ Other (Spec			phia Cr	' 1	5/05 Ph	iladelph	nia. PA
Baltimore,	그 본 변 군 .		21. Signature of Fundial Service Lie				s of Facility Bee			
Ď	Deperal Impo		- Cout y	CC044	12 2	053 Pul:	aski Hwy	. Nowar	P DE 10	ervices
			23a. Part1. Enter the disease, or co	mplications that caused the dea					K/ DE 13	Approximate
	Observation.		shock, or heart failure. List onl Immediate Cause (Final	y one cause on each line.	-	1.0.	1			Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	Due to (or as a conse	uc _	Coem	aucer			
	Examiner		7.0	Due to (or as a conse	quence or):					
		- E	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conse	quence of):					
18	per Ted	듣	cause. Enter Underlying							
	al-tre	Examiner	that initiated events resulting in death) Last	c Due to (or as a conse	quence of):					
58760,	cate be executed physician end the burial-trensit	18								
987		dicai		0.						
_	deeth certifi s ettending id for use as	Physician/Me	IF FEMALE:	23c. If yes, outcome of pregr	nancv	184			22d Date of delice	
Box	etter for L	Clar	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Fet 4 ☐ Pregnant at time of		Ectopic pregnancy Other (specify)			23d. Date of deliver	Day Year
o.	D 80 D	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	uousi 3 🗆	Cirier (specify)				
<u>α</u>	lew requires that the as been signed by th 2 should be detache		Part II. Other significant conditions	contributing to death but not re	sulting in the un	deriving cause give	n in Part I.	23e. Did tobacc	o use contribute to t	he cause of death?
ds,	sign d be	d by	-	<b>5</b>	•	, g called g.v.				ably 4 Unknown
Records,	w requir been s should	Completed						-		
<u>e</u>	has t	ם	<del></del>			<del></del>		24a. Was an autopsy	24b. Were auto	psy findings available mpletion of cause of
	: The cate his	Ö						performed 1 ☐ Yes 2 ☐ I		2□XNo
VItal	Phyeicien: this certific	Be	25. Was case referred to medical examiner?	11-1-2-1			26. Place of Death (	Check only one)		
o	hyet this o	P	1 ☐ Yes 2/ No	Hospital: 1 Inpatient 2			4 🗆 Nursing Home	5 Residence	6 ☐Other (Specif	y)
	D 5 5	Certification;	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at 28	d. Describe how in	ijury occurred	
<u>s</u>	Attending r death. ector: After by the fune	Cat	2 Accident investigation			M 1□Y	es 2□No			
Division	ier d frect	틭	3 Suicide 6 Could not determined		nome, farm, stre	et, factory, office	28	Location (Street City or Town, Sta	and Number or Rura ate)	il Route Number,
	ref D									
	Hoen Fune Fune	edical	(Check only 2 Medical Exa	hysician: To the best of my kn miner: On the basis of examin	owledge, death ation and/or inv	occurred at the time estigation, in my op	e, date and place, and inion, death occurred	due to the cause at the time, date a	(s) and manner as s	tated. the cause(s)
	To the Hospitel or Attendi within 24 hours efter death. To the Funerel Director: A completaly filled in by the fu	Med	one)	and manner stated.		29c. License				
	5. <u>₹</u> 5. §		29b. Signature and title of certifier			29C. LICENSE	number	29d. [	Date signed (Month,	
•			1/1/1/40			D3.	5453			005
	7		30. Name and address of person who	completed cause of death (Ite	m 23a) (Type, F	Print)	1	te 104 ElKtor		
			Martha Hoston	rd-Skapof, M	0 111	W. His	gh St	ElKtor	, mo &	(1921
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	E				
	Registr	ar	MAR 1 4 200	for the state of the	1					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** BETTY BARNES 38 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Sacred Hileganu If Under 1 Year If Under 24 Hrs. Heart 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min Months 1 ☐ M 2 🂢 F Yrs. SPRINGFIELD WV Director 08-01-1922 234-40-3425 82 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or itams 23a or 28a-f show the Medical Examiner must be notified at Yes 2 No Completed by Funeral Director WV MINERAL FORT ASHBY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itams 23a eny injury or other traumatic event, the Medical Evan net mustiness. PO BOX 422 26719 US 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE 3X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HOMER HAINES MARGARET V. FIELDS ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WVU HUMAN GIFT REGISTRY PO BOX 9131 MORGANTOWN WV 26506 20b. Place of Disposition (Name of cemetery, crematory or other place)
SUNSET MEMORAAL GARDENS UNKNOWN 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State <sup>¹</sup> 4 XDonation 5 ☐ Other (Specify) KINGWOOD WV 21. Signature of Funeral Service Licenses 22. Name and Address of Facility WVU HUMAN GIFT REGISTRY MORGANTOWN WV 26506 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) · Massive cerebrovascular accident **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed hysician and the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medicai IF FEMALE If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records, 2 No 3 Probably 4 Unknown 1 🗌 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed 2 No 1 Yes Division of Vital o the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural 1 🗌 Yes 2 🗌 No death. Director: , 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of 29c. License number 30. Name and a drifts of person who completed cause of death (Item 23a) (Type, Print)

OR Gary Wagoner 925 Bishop Walsh Road amberland, up 21502 31. Date filed (Month, Day, Year) Registrar's Signature State MAR 25 2005 Registrar

Physic /Med

Exam Funera

Directo

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itema 23a or 28a-f show any joury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examine

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Framework for the control of the con	10001
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Maryland Allegany  Maryland Allegany  Month Savage  106. City Town or Location  Maryland Allegany  Maryland Allegany  Month Savage  107. To Code  215. Goods  108. Care  109. Citizen of What Country  USA  Box 13515 Belle Star Road  12 Was Dependent of Hispanic Origin? (Specify You or No. 1) Place of Maryland Services of Mar	Maryland
16. December's Equipment Growth of the Control of College (1-4or 5-a)   16. December Usual Occupation (1/40 and of the control of College (1-4or 5-a)   16. December Usual Control of College (1-4or 5-a)   16. December Usual Control of College (1-4or 5-a)   16. December Usual Control of College (1-4or 5-a)   16. December Usual Control of College (1-4or 5-a)   16. December Usual Control of College (1-4or 5-a)   16. December Usual Control of College (1-4or 5-a)   16. December Usual Control October Usual College (1-4or 5-a)   16. December Usual Control October Usual College (1-4or 5-a)   16. December Usual	10d. Inside City Limits
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Don Teter    Jeckie Mae Carr   Jeckie Mae Carr   Jeckie Mae Carr   Jeckie Mae Carr   Jeckie Wilhelm-Daughter   Jeb. Mailing Address (Street and Number or Figual Route Number City or Town, State, Zip Co. Location - City or Town, State, Zip Co. American   Jeckie Mae Carr   Jeckie Wilhelm-Daughter   Jeb. March   Jeckie Mae Carr   Jeckie Wilhelm-Daughter   Jeckie Mae Carr	
19a. Informant's Name/Relationship (Type, Print)  Leslie Wilhelm-Daughter  Box 13515 Belle Star Road, Mt.Savage,    20a. Method of Disposition 1 (Squirial 2   Committion 3   Removal from State 1 (Squirial 2   Committee	
Leslie Wilhelm-Daughter  Box 13515 Belle Star Road, Mt. Savage, 120a. Manch of Disposition  Canada Date of Committed Star Road of March  Disposition   Disposition   Date    Canada Date   Date   Date   Date    Canada Date   Date   Date   Date    Canada Date   Date   Date   Date    Canada Date   Date   Date   Date    Canada Date   Date   Date   Date    Canada Date	
20a. Mathod of Disposition  1 (Squrai 2 Clorenation 3   Removal from State    20b. Pleas of Disposition   Marrich    White Oaks Cemetery25,2005   Marrich    White Oaks Cemetery25,2005   Marrich    White Oaks Cemetery25,2005   Mayersdale    21. Shature of Funeral Service Licenses    22. Apart and Address of Facility    23. Shature of Funeral Service Licenses    13.02 National Hwy, LaVale, MD 2150; Aparticology    23. Apart Enter the disease or complications that causilish the death. Do not enter the mode of dying, such as cardiac of respiratory arrest, and the second of	, ,
Signatural 2   Coremation   Committee	
21. Solution of Science Service Licenses   White Oaks Cemeteryy5, 2005   Meyersdale,   21. Solution of Funeral Service Licenses   13.02   National Hwy, Lavale,   MD 2150.   Application of Licenses   13.02   National Hwy, Lavale,   MD 2150.   Application of Licenses   Modern   Mod	r rown, State
23. Part I. Enter the diseast or complications that cause whe death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  A phock, or heart failure. List only one cause on each line.  Immediate Cause (find disease or condition and disease or condition and disease or condition and disease or condition.  Sequentially list conditions, if any, leading to mmediate Cause (find ground in death) Last  Due to (or as a consequence of):  Cause (Disease or injury resulting in death) Last  Due to (or as a consequence of):  Cause (Disease or injury resulting in death) Last  Due to (or as a consequence of):  Cause (Disease or injury resulting in death) Last  Due to (or as a consequence of):  Cause (Disease or injury resulting in death) Last  Due to (or as a consequence of):  Cause (Disease or injury resulting in death) Last  Due to (or as a consequence of):  Cause (Disease or injury resulting in death) Last  Due to (or as a consequence of):  Cause (Disease or injury resulting in death) Last  Due to (or as a consequence of):  Cause (Disease or injury resulting in death) Last  Due to (or as a consequence of):  Cause (Disease or injury resulting in death) Last  Due to (or as a consequence of):  Cause (Disease or injury resulting in death) Last  Due to (or as a consequence of):  Cause (Disease or injury resulting in death) Last  Due to (or as a consequence of):  Cause (Disease or injury resulting in death) Last  Due to (or as a consequence of):  Cause (Disease or injury resulting in death) Last  Due to (or as a consequence of):  Cause (Disease or injury resulting in death) Last  Due to (or as a consequence of):  Cause (Disease or injury resulting in death and place and place and place and due to the cause (a) and manner or flow or flow resulting in the underlying cause given in Part I.  Caterity in particular the line of death resulting in the underlying cause given in Part I.  Cate (Disease or injury resulting in the underlying cause given in Part I.  Cate (Disease or injury resulting in the underlying cause g	le,MD
23. Part I. Enter the diseast or complications that cause whe death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  A phock, or heart failure. List only one cause on each line.  Immediate Cause (find disease or condition and disease or condition and disease or condition and disease or condition.  Sequentially list conditions, if any, leading to mmediate Cause (find ground in death) Last  Due to (or as a consequence of):  Cause (Disease or injury resulting in death) Last  Due to (or as a consequence of):  Cause (Disease or injury resulting in death) Last  Due to (or as a consequence of):  Cause (Disease or injury resulting in death) Last  Due to (or as a consequence of):  Cause (Disease or injury resulting in death) Last  Due to (or as a consequence of):  Cause (Disease or injury resulting in death) Last  Due to (or as a consequence of):  Cause (Disease or injury resulting in death) Last  Due to (or as a consequence of):  Cause (Disease or injury resulting in death) Last  Due to (or as a consequence of):  Cause (Disease or injury resulting in death) Last  Due to (or as a consequence of):  Cause (Disease or injury resulting in death) Last  Due to (or as a consequence of):  Cause (Disease or injury resulting in death) Last  Due to (or as a consequence of):  Cause (Disease or injury resulting in death) Last  Due to (or as a consequence of):  Cause (Disease or injury resulting in death) Last  Due to (or as a consequence of):  Cause (Disease or injury resulting in death) Last  Due to (or as a consequence of):  Cause (Disease or injury resulting in death) Last  Due to (or as a consequence of):  Cause (Disease or injury resulting in death and place and place and place and due to the cause (a) and manner or flow or flow resulting in the underlying cause given in Part I.  Caterity in particular the line of death resulting in the underlying cause given in Part I.  Cate (Disease or injury resulting in the underlying cause given in Part I.  Cate (Disease or injury resulting in the underlying cause g	
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FEMALE:   23b. Was decedent pregnant in the past 12 months?   1   Live birth   2   Fetal death   3   Ectopic pregnancy   1   Live birth   2   Fetal death   4   Pregnant at time of death   5   Other (specify)   23d. Date of delivery   Month   Day   1   Yes   2   No   3   Probably   24a. Was an autopsy performed?   1   Yes   2   No   3   Probably   25. Was case referred to medical examiner?   1   Yes   2   No   3   Probably   25. Was case referred to medical examiner?   1   Yes   2   No   3   Probably   25. Was case referred to medical examiner?   1   Yes   2   No   3   Probably   25. Was case referred to medical examiner?   1   Yes   2   No   3   Probably   25. Was case referred to medical examiner?   1   Yes   2   No   3   Probably   25. Was case referred to medical examiner?   1   Yes   2   No   3   Probably   25. Was case referred to medical examiner?   1   Yes   2   No   3   Probably   25. Was case referred to medical examiner?   1   Yes   2   No   3   Probably   25. Was case referred to medical examiner?   1   Yes   2   No   3   Probably   25. Was case referred to medical examiner?   1   Yes   2   No   3   Probably   25. Was case referred to medical examiner?   26. Place of Death (Check only one)   26. Place of Death (Check only one)   27. Manner of Death   1   No. V.   28. Death of Injury   28. Directly   28. Dir	
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State 31. Date filed (Month, Day, Year) 32/Registrar's Signature	
istrar MAR 2 5 2005	

Registrar

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			1 - For State Registrar		aryland / De		nt of F	lealth a	and Me	F	giene	000	10235
	Physic	ian	Decedent's Name (First, Middle, Last	•						<ol><li>Date of Dea Month</li></ol>	Day	Year	3. Time of Death
	/Medi	cal	RUSSELL E.  4a. Facility Name (If not institution, give	BACON etract and sumber		45 6	Tour	r Location (		MARCH	21,		12:15p <sup>M</sup>
1	Exami	ner	10716 Cliff Rd	,				erto				County of Death	1
	Funeral		5. Social Security Number 6. S	9x 7. Ag	e (In yrs. last birtho	day) If Und	er 1 Year	If Under		Date of Birth (Month, Day			iplace (State or Foreign intry)
	Director		Usual Residence of Decedent	<b>⊉</b> M 2□F	74 Yr		s Days	Hours	Min.	oct 15	19:	30 New	Jersey
	arylar show	_	10a. State 10b. County		10c. City, Town o								10d. Inside City Limits
	the M	Funeral Director	MD Kent  10e. Street and Number		Chest								1 ☐ Yes 2 🔯 No
	with t	Ö	10716 Cliff Rd			10f. 2	Cip Code					en of What Cou	intry?
	heath ns 23	era	10 / 10 CIIII RU	12. Was Decedent I	Ever in U.S.	13 Was Dec	2162		gin? (Speci		U.S	• A • 4. Race - Amer	ican Indian
21215-0036	be filed within 72 hours after death with the Maryland hal Hygiene. so other than "natural", or Items 23a or 28a-f show event, the Madical Exacting must be notified at	by	1 ☐ Never Married 2 € Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ∰Yes 2 ☐ N If Yes, Give Year or Dates:	No			Specify:		fy Yes or No- can, etc.)		Black, White	
2-0	72 ho	Completed	15. Decedent's Ed (Specify only highest gra	ucation	16a. D	ecedent's Us	ual Occup	ation	t of working		16b. Kind	d of Business/li	ndustry
2	within ene.	nple	Elementary/Secondary (0-12)	College (1-4or 5	(+)	Give kind of vide. DO NOT					Corr	ugate	đ
	filed with Hygiene. other than		17. Father's Name (First, Middle, Last)	3	De	siyn	Engi			6	Cont	ainer	Designing
anc	abe f antal h and of	Be c	Wilbur Bacon							First, Middle, I Drrick		umame)	
Maryland	s i and 2 should be if Health and Mental I item 27 is marked of other traumatic events.	2	19a. Informant's Name/Relationship (7	vpe. Print)	19b. M	lailing Addre	ss (Street					Town, State, Zi	n Code)
	nd 2 lith a 27 ts r tra		Mary Bacon	(wife)		16 C						, MD.	
ē,	s 1 a of Hear item	11. 9	20a. Method of Disposition		20b. Place of D cemetery,				Date	-		ation - City or T	
E	Pages nent of int: If it		1 ☐ Burial 2 🛣 Cremation 3 ☐  '4 ☐ Dopation 5 ☐ Other (Specify	Removal from State	Kent (				3/22	/05	Smy	rna,	DE.
Baltimore,	permit. Pages 1 a Department of Hea Important: if item any injury or othe once.		21. Signature of figureral Suprior Licens	34 N	100510	Gale	na F West	ss of Facility uner _Cro	al Ho	ome of	f St Lena	ephen	L Schaech
	Pnysician /Medical		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a CTG \	bladd					espiratory arre	est,		Approximate Interval Between Onset and Death
þ	Examiner			Due to (or as a	a consequence of):								
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause, Disease or injury	b. Due to (or as a	a consequence of):								
#	be executed sician and burial-transit	Examiner	that initiated events	C									
0,	e exe ian a urial-t		resulting in death) Last		a consequence of):								
8760,	cate b physic the b	Jical		d.									
9 X	certific ding p	/Me	IF FEMALE:	23c. If yes, outcome of	of pregnancy								
P.O. Box	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birth  4 Pregnant at  9 Unknown	2 Fetal death	3 □Ectopic 5 □ Other (		·			23	d. Date of delive Month	ery Day Year
	w requires that been signed b should be deta	by	Part II. Other significant conditions co	ntributing to death bu	it not resulting in th	e underlying	cause give	on in Part I.			acco use		ne cause of death?
Vital Records,	The la ate has page 2	Completed								24a. Was ar autopsy perform 1 Yes 2	y ned?	24b. Were auto prior to co death? 1 🗌 Yes	psy findings available mpletion of cause of
Žį.	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Otho			Check only one			
o	Phys r this ral di	٦.	1 Yes 2 Alo	1 🔲 Inpatier			OA Dulle	" 4 □ Nur		5 Paside  1. Describe ho		Other (Specif	y)
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Division	f or Attending after death. Director: After I in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc.	ry - At home, farm, . (Specify)					Location (Str City or Town	eet and i State)	Number or Rura	l Route Number,
	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best oner: On the basis of and manner state	examination and/o	eath occurre r investigatio	at the tim n, in my op	e, date and inion, death	d place, and h occurred a	I due to the ca at the time, da	use(s) an	nd manner as si ace, and due to	ated. the cause(s)
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	5+1		30. Name and address of person who co	ompleted cause of de			0	088	1014	110	2	10/10	>
			31 Date filed (Atroch Day Years)	OPPO Prosing		Nain	6(-	09	una	MO	$\alpha$	1635	
	Sta Registr	-	31. Date filed (Month, Day, Year) MAR 2 5 2005	32. Registra	Is Signature	de							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year March 6, Mary Elizabeth Ray Beasley 12:45 P M 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 1950 Scientist Cliffs Road Port Republic Calvert | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | May 6, 1909 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 Ohio **Funeral** 1 🗆 M Yrs. 95 Director 226-36-2642 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If item 27 is marked other than "natural", or Itams 23s or 28s-1 show 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits traumatic evant. The Medical Examiner must be notified at Maryland Calvert Port Republic 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1950 Scientist Cliffs Road 20676 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes X☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No X ☐ Widowed 4 ☐ Divorced Specify: White Completed by 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th Secretary U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles Spence Essie Eppley 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Roger Amole- Executor permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or othar trai once. 437 North Lee Street Alexander VA 22314 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ➡ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Pohick Cemetery March18 2005 Lorton Virginia 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Rausch Funeral Home 4405 Broomes Is. rd. Port Republic MD 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CANCE COUN 10 mm /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Course (Lister Underlying that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attanding Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Completed by Physician/MedIcal the as use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the all d be detached fo 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No Canzer 3 Probably 1 Yes 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 22 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 - Homicide within 24 hours a To tha Funaral D To the Hospital 29a. Certifier 🛰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D46314 100 March 7, 2005

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State Registrar

Paul V. Pomila, M.D., 110 Hospital Rd., Suite 310, Prince Frederick, MD 20678

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year)
MAR 0 9 2005

נ /טו	Kas 3/8	/05	State of Maryland / Dep	partment of Health and Mental Hy ertificate of Death	(3) (3) (3) (m)
	Physic /Medi		1. Decedent's Name (First, Middle, Last)  CHARLES  J.	BRICE Month March	Day Year
	Examin Funeral Director		4a. Facility Name (If not institution, give street and number)  Washington Adventist Hospital  5. Social Security Number  6. Sex  7. Age (In yrs. last birthda)  7. 76  76  77. Yrs.	4b. City, Town, or Location of Death  Takoma Park  y) If Under 1 Year   If Under 24 Hrs. 8, Date of B, Month D	4c. County of Death  Montgomery County irth ay, Year)  9. Birthplace (State or Foreign Country)
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, the Markled Examiner must be notified at once.	To Be Completed by Funeral Director	Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or  MD  Calvert  10e. Street and Number  Manor  9201 Owings Hill Court  11. Marital Status  1 Never Married Married 3 Midowed 4 Divorced  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  12. Was Decedent Ever in U.S. Amed Forces?  1 No yet in U.S. Amed Forc		10d. Inside City Limits  1  Yes 2 No  10g. Citizen of What Country?  USA  o- 14. Race - American Indian, Black, White, etc.  Specify:  white  16b. Kind of Business/Industry  Federal Government  a, Maiden Sumame)  Nichter  Der, City or Town, State, Zip Code)
Records, P.O. Box 68760,	The law requires that the death certificate be executed Wedge 2 should be detached for use as the burial-transit	Completed by Physiclan/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown  Part II Other significant conditions contributing to death but not resulting in the	ng disease ind post-polio syndro  Clectopic pregnancy Other (specify)  underlying cause given in Part I.  23e. Did 1	Interval Batween Onset and Death  23d. Date of delivery Month Day Year  tobacco use contribute to the cause of death?  Yes 21 No 3 Probably 4 Unknown
Division of Vital Re	To the Hospital or Attanding Physician: The law within 24 hours after death.  To tha Funaral Director: After this certificate has I completely filled in by the funeral director, page 2 or	Certification; To Be	25. Was case referred to medical examiner?  1   Yes   No	ent 3 DOA Other: 4 Nursing Home 5 Resi of 28c. Injury at Work? M 1 Yes 2 No street, factory, office 28f. Location ( City or To	psy prior to completion of cause of death?  1 Yes 2 No No No No No No No No No No No No No
)	To the within 2. To that F complete	Medical	29b. Signature and rise of certifier  30. Name and address of person who completed cause of death (Item 23a) (Type	29c. License number 720362	29d. Date signed (Month, Day, Year)  March 3 2005  VK MP 20912
	Sta Registr		31. Date filed (Month, Day, Year)  MAR 0 7 2005  32. Registrar's Signature	P	

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State of Maryland / Department of Health and Mental Hygiene State Amend Item 12 per fh G841 3-29 C95 if Reale of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth-**Physician** 7:30 March 2005 PM Rudie С. Barte1 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location\_of Death 4c. County of Deeth Examiner Hospital Burnie orth rundel Anne 8. Date of Birth (Month, Day, Year) Sept. 4,1918 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days Hours 1∭ M 2□ F Country, Texas Sept. 86 Director 467-12-3404 Usual Residence of Decedent 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examinar must be notified at 1 X Yes 2 □ No Director Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3111 Teal Lane 20715 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? WW II 1 Xyes 2 No WW II If Yes, Give Korea/ Year or Dates; Vietnam 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White etc. 1 ☐ Never Married 2 ☐ Married 5-0036 1 ☐ Yes 2 X No Specify: à Specify: White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Maryland 2121 permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other than "any injury or other traumatic event, the Magnies. College (1-4or 5+) Elementary/Secondary (0-12) Computer Specialist U.S. Govt. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Bartel Meta Klemstein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Bartel / Son 3111 Teal Lane Bowie, Maryland 20715 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 04 - 11 - 05Arlington Nat. Cem. 4 ☐ Donation 5 ☐ Other (Specify) Arlington. VA. 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Service Licensee 6512 NW Crain Hwy. Bowie, Maryland 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Falluve cute **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner 0 MARST Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner death certificate be executed and Due to (or as a consequence of) burial-1 P.O. Box 68760, attending physician for use as the buris Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No autopsy page 1 Yes 2 No or Attanding Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 ER/Outpatient 3 DOA in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Medical Certification: 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation To the Hospital or Attandi within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) March 9, 2005 D41365 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)
George E. Wills M. M.D. 301 HOSPITAL Drive, Glen Burnie, MD. M.D. JEDVAL 31. Date filed (Month, Day, Year) State MAR 1 1 2005 Registrar

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			1 - For State Registrar	State of Mai	ryland /	•	artment of H			iene g. No.	005	10239
			1. Decedent's Name (First, Middle, Las	st)					2. Date of Deat Month	Day	Year	3. Time of Death
ı	Physici /Medio		Ruth Alice	Barry					March	7, 20	005	3:30 P M
	Examir		4a. Facility Name (If not institution, give					Location of Deat	n		unty of Death	
			Anne Arundel Medi				Annapo	Lis If Under 24 Hrs.	10.5		ne Aru	
ı	Funeral Director		123-20-3030	ex 7. Age 7. Age 84	(In yrs. last I	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 7–30–19	Year) 20	9. Birth Cou Mair	place (State or Foreign ntry) 1e
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Lo	cation					10d. Inside City Limits
	Maryl f sho	ō	Maryland Anne Ar	undel		Δnn	apolis					1 ☐ Yes 2 X No
	the 1	rec	10e. Street and Number	anaer		71111	10f. Zip Code		10	0g. Citizen	of What Cou	ntry?
	3a o	i i	912 Topmast Way				21401			J	JSA	
336	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other then "natural, or Items 23a or 28e-f show or other traumatic event, the Medical Examinate in the Indiffical at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 Å No If Yes, Give Year or Dates:	ver in U.S.	1	Was Decedent of H if Yes, specify Cuba 1 ☐ Yes 2X No	ispanic Origin? (S In, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)		Race - Ameri Black, White, ecity: Wh	
ğ	2 hou	ted	15. Decedent's Ed		16	a. Deced	dent's Usual Occup	ation	diaa	16b. Kind	of Business/In	ndustry
Maryland 21215-0036	2 should be filed within 7 and Mental Hygiene. Is marked other than "n aumatic event, I'm Ned	Completed	(Specify only highest gra  Elementary/Secondary (0-12)  12th	College (1-4or 5+)		life.	kind of work done of DO NOT use retired VISORY BU	1)		Feder	ral Cov	ernment
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au	fental fental rked	To B	Fred Lowell					Mary	T. Sween	ey		
ary	shou s ma		19a. Informant's Name/Relationship (	Type, Print)	19	9b. Mailir	ng Address (Street	and Number or Ru	ıral Route Number,	City or To	own, State, Zip	code)
Σ	and 2 saith a n 27 is		Thomas F. Barry/	Son				ve., Dea	le, Mary			
altimore,	of He		20a. Method of Disposition  1 Surial 2 Cremation 3 C	Removal from State	ceme	tery, crer	sition (Name of natory or other plac				ion - City or To	
Ĕ	Pag ment ent: lury c		`4 Donation 5 Dother (Specifi	1)	Resur		ion Cemet				on, MD	
Ball	permit. Pages 1 and 2 s Department of Health an Importent: If Item 27 Is any injury or other trau		21. Signature of Suneral Service Licer	see					eorge P. :			
8760,	The law requires that the death certificate be executed  The law requires that the death certificate be executed  The law required to the attending physicien and the latter and the latter are the latter and the latter are the latte	dicai Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a b. Due to (or as a c. Due to (or as a d.	consequenc	e of):	A				7	Onset and Death UREE DA-95
O. Box 6	that the death certific ed by the attending p detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	☐ Fetal dea		Ectopic pregnancy Other (specify)			23d	Date of deliver	ery Day Year
ds, P	uires that signed b	þ	Part II. Other significant conditions of	ontributing to death but	not resulting	in the u	nderlying cause give	en in Part I.	23e. Did tob	V		he cause of death?
Il Records,	ysicien: The law requir is certificate has been si director, page 2 should	Completed							24a. Was ar autopsy perform 1 🗆 Yes 2	/	4b. Were auto prior to co death? 1 🗆 Yes	opsy findings available impletion of cause of
Vita	icien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			oth	O.P.	ath (Check only one			
	Phys this al dir	- To	1 Yes 22 No  27. Manner of Death	28a. Date of Injury		Dutpatien  Time of	IL JUDON	4   Iduising i	lome 5 Reside			(y)
Division of	Attanding Physicien: r death. ector: After this certification of the funeral director, in	ation	Natural 5 Pending investigation	(Month, Day)	Year)	Injury	Worl		Edd. Doddillo 110	w inquity oc	ouried.	
Š	Hospitel or Attank 24 hours after death Funerel Director: tely filled in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	y - At home, (Specify)	farm, str	eet, factory, office		28f. Location (Str City or Town		umber or Rura	al Route Number,
		Medical C		ysician: To the best of niner: On the basis of e and manner state	examination a							
ı	To the within 2 To the complet	Me	29b. Signature and title of certifier	ne		d/\	29c. License	224	5 12	d. Date si	gned (Month,	Day, Year)
			30, Name and address of person who	completed cause of dea	ath (Item 23a	a) (Type,	Print)	ı			. 3/	21401
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	Sta		31. Date filed (Month, Day, Year)	39. Registrar	's Signature			,	-		V	/
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			State of Maryland / Department of Health a Certificate of Death			ene 2005	10240
Ī			1. Decedent's Name (First, Middle, Last)		ate of Death		3. Time of Death
ı	Physici /Medio		Hazel Bufkin	Mar		2005 Year	7:15 pm
and a	Examir		4a Facility Name (If not institution, give street and number)  4b. City, To	Town, or Location	of Death	4c. County of Deat	1
				hicum		Anne Ar	
	Funeral Director		5. Social Security Number 6. Sex $1 \square M$ $2 \boxtimes F$ 7. Age (In yrs. last birthday) 1f Under 1 Year 1 Year 1 Yea	Min. 8. Da  Min. (M	te of Birth lonth, Day, Y	(ear) 9. Birti 1920 Mar	nplace (State or Foreign untry) Yland
	and		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location				10d. Inside City Limits
	ath with the Marylan 23a or 28a-f show	5					1 ☐ Yes 2 ☐No
	28a	rect	Maryland Anne Arundel Annapolis  10e. Street and Number 10f. Zip Code		100	g. Citizen of What Co	untry?
	3a or	Funeral Director	3255 Arundel on the Bay Road 21403			US	
	death	ner	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Ori	rigin? (Specify Y	es or No-	14. Race - Ame	ican Indian,
2-0020	filed within 72 hours after death with the Maryland Hygiene. yther then "naturali, or items 23a or 28a-f show ent, the Medical Examinat must be notified at	by	Armed Forces? If Yes, specify Cuban, Mexican 1 Never Married 2 Married 1 Yes 3 No If Yes, Give 1 Yes 2 No Specify:		etc.)	Black, White	Black
2	72 ho	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during mos	et of working	16	b. Kind of Business/l	ndustry
7	be filed within 7 hal Hygiene. d other than "n event, the Medi	nple.	Elementary/Secondary (0-12) College (1-4or 5+)	ist of working			
7	e filed within al Hygiene. I other than 'went, Ite Me	ပ္ပ	12th 0 Nursing Assista			nnapolis	Nursing
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ē,	一工戶	ŀ	Patricia Cole (Daughter) 3255 Arundel or 20a. Method of Disposition (Name of 20b. Place of 20b. Place of 20	n the E	e 20	d . Annap c. Location - City or	OLIS, MC. Fown, State
Ē	Pages nent of I nrt: If ite iry or o		pChBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  Approximately crematory or other place)  Hill Crest Cemetery	v 3/1	0/05	Annapol	is, Md.
baltimor	# 문문음	ŀ	21. Signature of Funeral Service Licensee 22. Name and Address of Facilities		•		· · ·
ם	Dermi Depa impo any ir	i	Larry H. Ress Mos 483 Wm. Reese & S 821 West St.	Sons Mo	rtua	ry, P.A.	0.1
9			23a. Part1. Enter the d. ease, or complications that caused the death. Do not enter the mode of dying, such as shock, or heart failure. List only one cause on each line.	s cardiac or respi	iratory arrest	Mu. 214	Approximate Interval Between
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	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  a. ANTEMOS CHENOS CAUSE	TO VASCE	hr l	) Heare	years
		<u>.</u>	Due to (or as a consequence of):				·
	uted d ansit	Examiner	Sequentially list conditions.  Due to (or as a consequence of):				
Ď	icate be executed physician and s the burlel-transit	Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c.				
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5	the de	ysic	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I	: I.			to the cause of death?
Ļ	The law requires that the ate has been signed by the page 2 should be detache	by Ph	Cerebral Thrombosis		1 🗆 Yes	2 ⊒fNo 3 □ Pr	obably 4 🗆 Unknown
Solos,	quires n sigr uld be		Ceremal Thrombosis	24	ta. Waş an a		Vere autopsy findings
5	w rec s bee	Completed	Demento		performe	C	vailable prior to ompletion of cause f death?
ב	he la te has age 2	E		140	1□ Yas	/	□Yes 2□No
ō	an: tiffica	BeC	25. Was case referred to medical 26. Place	ce of Death (Chec	ck only one)		
>	Physician: r this certificant and director,	2	examiner?  1   Yes 2   No	lursing Home 5	Residence	ce 6 Other (Spec	ity) byospiez
5	fter thunera		27. Manner of Death 28a. Date of Injury 28b. Time of 1 ☑Natural 5 ☐ Pending (Month, Day Year) 28b. Time of 1 ☐Natural 5 ☐ Pending (Month, Day Year) 28b. Time of 1 ☐Natural 2		escribe how	injury occurred	
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$\leq$	or At efter o Direc	Certlfication:	4 Homicide  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	281. Lo	y or Town, S	et and Number or Ru. State)	ai Houte Number,
_	spital	<u>a</u>	29a. Certifier 1 Certifying Physician: To the heat of my knowledge, doubt occurred at the time data an	nd plane, and du	to the cour	se(s) and manner as	stated.
	To the Hospital or Attending Physicien: The law within 24 hours efter death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deal and manner stated.	ath occurred at th	ne time, date	and place, and due	to the cause(s)
	To t To t	_	29b. Signature and title of certifier 29c. License number	0		. Date signed (Month	
)			Danklender Dole	112	N	1ARCH 9	2005
		Į.	30. Name and address of person who completed cause of death (Item 23a) (Type Print)  PAI A DEVICE MD 4203 QUEENSEUPY	Rd Hy	catts	JARCH 9	20781
	Stat Registra	e ar	31. Date filed (Month, Day, Year) 11. Date filed (Month, Day, Year) 2005				
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			For State Registrar	State of I	Marylan		artment rtificate			and M		Reg. No	13 m	15	10241
	Physici /Medic Examir	al	1. Decedent's Name (First, Middle  Ruth  4a. Facility Name (If not institution)	E1	1en Ortal	F	lonsk 4b. Gity, 1		Location o	f Death	2. Date of D Month O3	lO.	County o	Year 5 Death	3. Time of Beam
	Funeral Director		5. Social Security Number 213-24-6194 Usual Residence of Decedent		Age (In yrs. I	Yrs.	If Under Months	1 Year Days	If Under a	24 Hrs. Min.	8. Date of B (Month, D 07/22	lirth Day, Year) /1917	7	Cour	place (State or Foreign otry) Land
1 21215-0036	iiit. Pages I and 2 should be filled within 72 hours after death with the Maryland ariment of Heath and Mental Hygiene. ortent: if item 27 is marked other then "naturel", or items 23e or 28e-f show njury or other treumetic event, I're Macacal Existing investive notified at 6.	Completed by Funeral Director	10a. State 10b. County  MD A11  10e. Street and Number  407 Valle  11. Marital Status  1 Never Married 2 Marri 3 Widowed 4 Divorced  (Specify only highes)  Elementary/Secondary (0-12)  12  17. Father's Name (First, Middle, 100)	12. Was Decede Armed Force 1	nt Ever in U.S s? Mo s:	S. 13. \\ 16a. Decec (Give life. I	ımber1 10f. Zip	ent of His fy Cubar No Occupa k done de retired)	Specify: tion uring most	of workir		16b. Ki	14. Race Black, Specify: ind of Busi	Americ White,	ean Indian, etc. Thite
Baltimore, Maryland	permit. Pages 1 and 2 should be for Department of Health and Mental Importent: If item 27 is marked of any njury or other treumetic ever once.	To Be	John  19a. Informant's Name/Relations Edward C. Cros  20a. Method of Disposition  1 \( \text{Name} \) Burial 2 \( \text{Cremation} \)  4 \( \text{Donation} \) 5 \( \text{Other} \) (Signature of Pineral Service I	E.  Sip (Type, Print)  Sisland/ fri  3 □Removal from Statecify)	end	1 Walace of Dispo emetery, cren Luke	ng Address ashing sition (Nam natory or oth 's Cer	(Street and Street and	Berind Number Stre	tha rorRura. et,  3/12 Ad		ber, City of land	ockho  r Town, Si  MD  cation - C  umber  Fune	use 215 ity or To 1ane	502
Box 68760,	death certificate be executed  Wedical  e attending physician and for use as the burial-transit	Physician/Medical Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	a	as a consequas a consequ	ence of):	Ectopic pre	gnancy	, such as o	cardiac oi	respiratory		23d. Date « Month		Approximate Interval Between Onset and Death
Vital Records, P.O.	law requires that the d as been signed by the 2 should be detached	Completed by Physic	Part II. Other significant conditio	9□ Unknowr	1		Other (spe		n in Part I.		1 24a. Was	Yes 20 s an opsy ormed?	No 3	Proba	e cause of death?  ably 4 Unknown  by findings available opletion of cause of
Division of Vital	tending Phyeicien: leath. tor: After this certifica the funeral director, t	Certification; To Be C	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death  1  Natural 5  Pending investig 2  Accident 3 Suicide 6 Could n determi	ation of be 28e. Place of	njury Day Year)	ER/Outpatient 28b. Time of Injury me, farm, stre	28 M	Other c. Injury : Work? 1  Ye	4 🗆 Nur	sing Hom 2	1 Yes Check on 18 5 Res 8d. Describe  8f. Location ( City or To	idence 6 how injury	Other	(Specify	2 No
]	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	Medical Ce	29b. Signature and title of certifier	g Physicien: To the be examiner: On the basis and manner	or examinati	on ang/or inv	ASTIMATION I	n my oni	nion doath	1 ACCULTED	d at the time.	data and	0000 300	due to	the cause(s)
	アム Sta Registr		30. Name and address of person we have a second of the sec	and manner and manner who completes cause of Smith man 32. Reg	f death (Item 900 firar's Signati	Seton Seton	Sports	Can	beeld	, l	MO 2	1502	-		

			1 - State Registrar	Maryland / Depa			Mental Hyg	leg. No. ZU	05	102	42
	Physici	an	1. Decedent's Name (First, Middle, Last)  Charlotte M. Burley				2. Date of Dea Month	th 2005	Year	Time of D	
	/Medi Examir		4a. Facility Name (If not institution, give street and nun	nber)	4b. City, Town,	or Location of Deal		4c. County (		0502	A <sup>M</sup>
			MEMORIAL HOSPITAL		CUMBERL			ALLEG	ANY		
	Funeral Director		5. Social Security Number  214 07 3429  Usual Residence of Decedent	7. Age (In yrs. last birthday) 95 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		1909	9. Birthplace Country) MD	(State or I	Foreign
	e Maryland ta-f show littled at	ctor	10a. State 10b. County MD Allegany	10c. City, Town or Lo Corrigan						nside City	
	th with th 23a or 20 ust be no	Funeral Director	100. Street and Number 12513 Jennings Way		10f. Zip Code 21524		1	0g. Citizen of W USA	hat Country?		
9800	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other then "naturel", or items 23s or 28s-f show other treumatic event. The Medical Examiner must be notified at	by	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  1 YXWidowed 4 Divorced  12. Was Dece Armed For 1 Yes, Giv Year or Day	<b>2/CX</b> No	Was Decedent of I If Yes, specify Cub		pecify Yes or No- to Rican, etc.)	Black	- American In K, White, etc. White	ndian,	
Maryland 21215-0036	filed within 72 h Hygiene. rthar then "natu ant, the Mey cal	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1	(Give life.	dent's Usual Occu kind of work done DO NOT use retire MARET	pation during most of wo d)	rking	16b. Kind of Bus	siness/Industry	у	
yland	2 should be file and Mental Hyg is marked oths eumatic event,	To Be C	17. Father's Name (First, Middle, Last)  Asa (mnu) Stuckey			Elizabe	me (First, Middle, 1 th (mnu)	Holt			
Mar	th and 2 sh and 11th and 27 is m		19a. Informant's Name/Relationship (Type, Print)  Richard L. Burley, son				ural Route Number			θ)	
Baltimore,	parmit. Pages 1 and 3 Department of Health Important: if item 27 any injury or other tr. 20028.		20a. Method of Disposition  VIZ Burial 2 Cremation 3 Removal from S  4 Donation 5 Partial (Specify)	20b. Place of Dispo	sition (Name of natory or other pla	сө)	Date	20c. Location - (	City or Town, S	State	
Balti	parmit. Pages: Department of H Important: if ite any injury or ot		21. Signature of Funeral Service Liverage	22	Name and Addre	ass of Facility	Funeral			PA	
	Physician /Medical Examiner	-	Due to (c	used the death. Do not entrich line.  STIVE HEART or as a consequence of):  or as a consequence of):		ng, such as cardia	c or respiratory arra	est,	Inter	roximate rval Betwe et and De VEEK	
8760,	The law requires that the death cartificate be executed the bas baen signed by the attending physician and agge 2 should be detached for use as the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	or as a consequence of):							
.O. Box 6	at the death cartifica by the attending ph tached for use as th	Physician/Med	in the past 12 months?	int at time of death 5	Ectopic pregnanc Other (specify)	y		23d. Date Mont	of delivery th Day	Yea	ar
Records, P	w requires that baen signed I should be det	by	Part II. Other significant conditions contributing to de	ath but not resulting in the ur	nderlying cause giv	ven in Part I.		pacco use contrit es 2□No 3	oute to the cau	. /	
al Reco		Completed					24a. Was a autops perform 1 Yes	y pr ned? de	ere autopsy fir ior to completi eath? Yes 2[]1	ion of caus	
Vital	Physiclen: This certificaral director, p	o Be	25. Was case referred to medical examiner?  1 □ Yes 2 ☑ No Hospital: 1 ☑ Ir	patient 2 ER/Outpatien	t 3 DOA Oth		ith (Check only on ome 5 ☐ Reside		(Specify)		
ion of	Attending Phy r death. ector: After thi by the funeral o	ation: T	27. Man er of Death 1 V Natural 5 Pending (Month 2 Accident investigation		28c. Injui Woo		28d. Describe ho				
Division	tei or Atters after de ai Directo	Certification:	3 Suicide 6 Could not be determined 28e. Place buildin	of Injury - At home, farm, stre g, etc. (Specify)	eet, factory, office		28f. Location (Sti City or Town		r or Rural Rou	te Numbe	r,
	To the Hospitel or within 24 hours after To the Funeral Dire completely filled in b	Medical	29a. Certifier (Check only one)  1 V Certifying Physicien: To the 2 Medicel Examiner: On the base and mann	sis <b>of</b> examination and/or inv	occurred at the til restigation, in my o	ne, date and place pinion, death occu	, and due to the ca rred at the time, da	use(s) and man ate and place, ar	ner as stated. nd due to the c	ause(s)	
	To th To th comp	Me	29b. Signature and title of certifier		29c. Licens	e number	29	9d. Date signed	(Month, Day,	Year)	
	4		Jilmy -	of death /h = oc \ T	D36	766	M	ARCH 14	, 2005		
	nds		DR. VIK POONAI, 924 SETON		,	MD 21	502				
	Sta · Registr	te	31. Date filed (Month, Day, Year) MAR 1 4 2005 32. P	gistrar's Signature	back						

			For State Registrer		State of	Marylar		artmen rtificat				lental Hy	giene 2	005	1024
	Physic /Medi		1. Decedent's Name		ore Joseph	Brue	ckman	n,Sr.				2. Date of De Month March		2005	3. Time of Death 6:20 AM
	Exami		4a. Facility Name (I	f not institution	, give street and nun	nber)		4b. City,	Town, or	Location	of Death		4c. Coi	unty of Death	
					& Rehab			-	rlin				Wor	cester	
	Funeral Director		5. Social Security N 216-20-30 Usual Residence of	066	6. Sex 1 <b>½</b> M 2□F	7. Age (In yrs. <b>79</b>	last birthday Yrs.	Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Oct.3	y, Year)	9. Birthpl Coun MD	lace (State or Foreign try)
	land ow		10a. State	10b. County		10c. Ci	ty, Town or L	ocation						10	Od. Inside City Limits
	Marylan -f show iled at	ţō	MD	Worce	ster		Ocean	City							1 ☐ Yes 2 🗙 No
	n the	Director	10e. Street and Nur	mber				10f. Zip	Code				10g. Citizen	of What Coun	try?
	th with	a D	10347 Go	If Cour	se Rd.			21	842				US		
036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event. I'm Medical Evantract must be notified at	d by Funeral	11. Marital Status 1 ☐ Never Marri 3 🎇 Widowed		12. Was Dece Armed For 1 XYes If Yes, Giv Year or Da	ces? 2 <b>19</b> 41-1		Was Deced If Yes, spec	cify Cuba	ispanic Or n, Mexical Specify:	n, Puerto	ecify Yes or No Rican, etc.)		Race - America Black, White, e ecify: Whi	etc.
21215-0036	within 72 h ene. then "natu	Completed	(Specification (Speci		's Education it grade completed) College (1	-4or 5+)	(Give	dent's Usua e kind of wo DO NOT us Manag	rk done a se retired,	turina mos	st of worki	ing		Plant	ustry
Maryland 2	uld be filed fental Hygid rked other tic event,	To Be Co	17. Father's Name		ntine Brue	ckman	- <del></del>					eller Cl	Maiden Sun	name)	
	and 2 should I salth and Men n 27 Is marke ier traumatic		19a. Informant's Na Theresa		nip <i>(Type, Print)</i> (daughte)	r)						Noute Number			
altimore,	Page nent c ant: If ary or		20a. Method of Disp 1 Burial 2 4 Donation	Cremation	3 □Removal from Specify)	State _ C	Place of Disponentery, cre	matory or o	ther place			-05		on - City or Too ford, D	
Balt	permit. Pag Department Important: I any injury o		21. Sign für Fu	Service I	Surles	_						e Burb rlin, M			Home
	Physician /Medical Examiner	Examiner	23a. Părt1. Enter ti shock, or hea Immediate Cause (disease or condition resulting in death)  Sequentially list con it any, leading to in cause. Enter Unde Cause (Disease or that initiated events	Final n n n n n n n n n n n n n n n n n n	b	aused the deat ach line. Consequence as a consequence as	puence of):					Prespiratory and Press Control			Approximate Interval Between Onset and Death
Box 68760,	the death certificate be executed y the attending physician and iched for use as the burial-transit	Physician/Medical Exa	resulting in death) L  IF FEMALE: 23b. Was decedent in the past 12	pregnant	d. 23c. If yes, outd	rth 2 ☐ Feta	ancy Ideath 3[	□Ectopic pr						Date of deliver	y Jay Year
P.O.	the d y the	by	1 Tyes 2 5 9 Unknown Part II. Other signifi		9☐ Unkno			Other (sp		in in Part I			bacco use c	ontribute to the	cause of death?
Records,	The law requires that ate has been signed by page 2 should be deta	ompieted										24a. Was autop	sy megl?	b. Were autop prior to com death?	sy findings available pletion of cause of
Vital		e C	25. Was case refer	red to medical						26 Place	of Death	1 ☐ Yes	No	1 ☐ Yes 2	2 🗀 No
Ž	S S	0 8	examiner? 1 ☐ Yes	No	Hospital:	patient 2	ER/Outpatier	nt 3 🗆 DO	A Othe	e /		ne 5 Resid		Other (Specify)	
ion of	sing Funel	ation: T	27. Manner of D ath 1(ZNatural 2 ☐ Accident	5 Pending	,	f Injury n, Day Year)	28b. Time o Injury	_	Bc. Injury Work	at	2	8d. Describe h			
Division	tal or Attenders safter death al Director: ed in by the	Certification:	3 🗍 Suicide 4 🗋 Homicide	6 ☐ Could n determi	ned 286. Place	of Injury - At ho g, etc. (Specif	ome, farm, str y)	reet, factory	, office		2	28f. Location (5 City or Tow	treet and Nu n, State)	mber or Rural	Route Number,
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edicai	29a. Certifier (Check only one)	Z Medicel E	Physicien: To the laxeminer: On the ba	sis of examina	wledge, deat tion and/or in	h occurred a vestigation,	at the time in my op	e, date an inion, dea	d place, a	and due to the o	ause(s) and date and plac	manner as sta e, and due to t	ted. he cause(s)
)	To t To 1	M	29b. Signature dis	title of certifier	ruele	C.	us	> [	License 2	number >	69	7	29d. Date sig	ned (Month, D	ay, Year)
H	5+1		30. Name and addre	ess of person v	who completed cause	and	)	Print) 15	209 w.	che Ce	45	al It	De	7 19	744
	Sta Registr	7.7	31. Date filed (Mont	MAR 1	2005	gistrar's Signa	ture	park	,						· · · · · · · · · · · · · · · · · · ·

			1 - For State Registrar		State	of Maryl	and / De <sub>l</sub>	oartmer e <i>rtificat</i>				1ental Hy	giene	7005	102	ls ls
	Physici		Decedent's Name (First, Midd     SHIRL	R.	t)	BAI	RUWA					2. Date of De Month March	Па	2005 Year	3. Time of 19:58	Death PM
	/Medic Examir		4a. Facility Name (If not institution	n, give	street and no	ımber)		4b. City,	Town, or	Location	of Death			. County of Dea		
			Shady Grove A	dve	ntist	Hospit	a1	Roc	kvi1	1e			M	lontgome	ry	
	Funeral		5. Social Security Number	6. Se	x ⊒M 2⊠F	7. Age (In	yrs. last birthda	) If Unde Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi	rth ay, Year)	9. Bii	thplace (State of ountry)	r Foreign
	Director		577-64-0032 Usual Residence of Decedent				55 Yrs.					Jan. 1	5,19	50 Sou	th'Caro	lina
	land		10a. State 10b. Count	/		10c	. City, Town or	Location							10d. Inside Cit	y Limits
	Mary 18h	to	Maryland Mont	gom	erv		Germanto	าพา							1 🗆 Yes	2 X No
	r 28a	Director	10e. Street and Number	0 -				10f. Zip	Code				10g. Cit	tizen of What C	ountry?	
	th with		20625 Boland	Fa	rm Roa	d			2087	6				U.S.A		
	ems err	Funerai	11. Marital Status		12. Was Dec	cedent Ever i	in U.S. 13	. Was Dece	dent of H	ispanic Ori	igin? (Sp	ecify Yes or No Rican, etc.)	o-	14. Race - Am Black, Whi	erican Indian,	
36	or it	by Fu	1 ☐ Never Married 2 ☑ Ma		1 ☐ Yes If Yes, G	2 XINo ive		1 🗆 Yes		Specify:		1 110411, 010.7		Canalifu		
Ö	72 hours after death with the Maryland natural', or items 23a or 28a-1 show disal Evertiver roust be notified at	q pa	3 Widowed 4 Divorce		Year or I	Dates:	16- D	- 11	-10:					BT	ack	
5	C 2 30	Completed	15. Decede (Specify only highe		de completed		(Giv	edent's Usu e kind of wo DO NOT u	rk done d	durina mos	t of work	ing	16b. K	(ind of Business	/Industry	
212	d within giene. rr than "	omp	Elementary/Secondary (0-12)		College	(1-4or 5+) 4		inistr		,	ista	int	R	etail		
ק	i Hyg othe	ø	17. Father's Name (First, Middle	Last)						18. Mothe	er's Name	e (First, Middle	, Maiden	Sumame)		
<u>lar</u>	uid by Wenta vrked tric e	To B	Marion Ranson							Mabe	1 Be	nnett				
Maryland 21215-0036	2 should be and Mental is marked or raumatic eve		19a. Informant's Name/Relation											or Town, State,		
2	and eelth m 27		Lateef L. Bar	uwa	/ Hus		-		-	Farm		-		wn, MD		
Baltimore,	P Fig.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation			State	b. Place of Dis cemetery, cr	ematory or c	ther plac			Date		ocation - City or		
# H	t. Pa rtmen rtant: njury		*4 □Donation 5 □ Other (	£	£		Sate of							ver Spr		
Bal	permit. Pages 1 and 2 should be Department of Heelth and Menta Important: If Itam 27 is marked any injury or other traumatic av once.		21. Signature of Funeral Signature	1	de	Sa		1800	New	Hamps	hire	Ave.	Silv		al Home, ng, MD 2	
	Physician /Medical	and an analysis	23d Part 1. Enver the disease, c shock of heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	r comp t only o	a	each line.	sequence of):	nter the mod	le of dying	g, such as	cardiac o	or respiratory a	rrest,		Approximate Interval Betw Onset and D	eath
	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Į	b. Due to	(or as a con	sequence of):									
,8760,	cate be executed physician and the burial-transit		that initiated events resulting in death) Last	l	Due to	(or as a con	sequence of):									
.O. Box 6	death certifi e attending ed for use as	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ₩ No 9 □ Unknown	:		birth 2 ☐ F nant at time	Fetal death 3	□Ectopic pr						23d. Date of de Month		ear .
s, P	ngi pe		Part II. Other significant condit	ons co	entributing to d	death but not	resulting in the	underlying c	ause give	on in Part I.			obacco i		the cause of de	
Vital Record	The law ate has b page 2 s	Completed										24a. Was auto perfo 1 \( \text{Yes}	psy prmed?	prior to death?	utopsy findings a completion of car	vailable use of
/ita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?									Check onl				
of	o o	D 10	1  Yes 2 No				ER/Outpati							6 □ Other (Spe	cify)	
	Attending I r death. ector: After by the funer	ation	27. Manner of Death  1  Natural 5 Pendi 2 Accident invest	ng igation	28a. Date (Mor	of Injury oth, Day Year	r) 28b. Time Injury	of 2	8c. Injury Work 1 🔲 ۱	at ? /es 2 □ 1		28d. Describe	how injur	ry occurred		
=	in the o	Certification:	3 Suicide 6 Could 4 Homicide deterr		28e. Plac build	e of Injury - A ling, etc. (Sp	At home, farm, s ecify)	treet, factory	, office			28f. Location (. City or To			ural Route Numb	er,
	To the Hospital within 24 hours a To the Funerel Completely filled	edicai	29a. Certifier 1 Certifyi (Check only one) 2 Medical	ng Phy Exami	iner: On the b	e best of my pasis of exam ner stated.	knowledge, dea nination and/or	ath occurred nvestigation	at the tim , in my op	e, date and pinion, deat	d place, a	and due to the ed at the time,	cause(s) date and	and manner as d place, and due	stated, to the cause(s)	
	To ti To ti comp	M	29b. Signature and title of certific	er				290	License	number	10		29 d. Dat	te signed (Mont	h, Day, Year)	
)	1								158	87	11		3/01	7/05	•	
	G		30. Name and address of person				, , , , ,	,					l	/		
	Sta	10	DAVID NAHUM KI 31. Date filed (Month, Day, Year			9901 N Registrar's Si	<u>ledical</u>	Cente	r Dr	ive,	Rock	ville,	Mar	yland 2	0850	
	Sta Registr			20	05 /	Registrar's Si	K A	ale								

			101	partment of Health and Meartificate of Death		ene . No 2005	10215
	Physicia	an	Decedent's Name (First, Middle, Last)		2. Date of Death Month March 7	Day Year	3. Time of Death
	/Medic	al	Margaret Louise Becker  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	March /	4c. County of Death	6:05 P. M
	Examin	er	Wilson Health Care Center	Gaithersburg		Montgome	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birth Cou	place (State or Foreign intry)
	Director		Usual Residence of Decedent		June 7, 192	27   Colo	orado
	iryland ihow	_	10a. State 10b. County 10c. City, Town or L Maryland Montgomery Gaithers				10d. Inside City Limits
	he Ma 28a-f s	ecto			1.40		1 <b>2</b> Yes 2 □ No
	3a or 3	I DI	401 Russell Avenue Apt. 714	10f. Zip Code 20877	10g.	Citizen of What Cou. United St	•
	Bms 2	nera		. Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto F	cify Yes or No-	14. Race - Ameri Black, White,	ican Indian,
36	s after	y Fu	1 Never Married 2 Married 1 Yes 2 No	1 ☐ Yes 2 ☐ No Specify:	110411, 010.)	Specify: Whi	
21215-0036	72 hours after death with the Maryland Insturel', or items 23a or 28a-f show Ucal Examiner must be nutified at	Completed by Funeral Director	15. Decedent's Education 16a. Dec	edent's Usual Occupation	168	b. Kind of Business/Ir	ndustry
215	ithin 7, ie. ien "n	nple	Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of workin DD NOT use retired)	ng		
121	illed w Hygier ther th nt, the	Cor	12 Sea	amstress 18. Mother's Name	(First Middle Mai	Clothing	
lan	lid be fental i	To Be	R. A. Becker	Frances	Brandner		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury go other traumatic avant, the Madical Examiner must be nutified at once.			ling Address <i>(Street and Number or Rural</i> Mercado Way, Gait		, , ,	· · · · · · · · · · · · · · · · · · ·
Baltimore,	of Head of Head of Head		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  20b. Place of Disposition	position (Name of Department of March	ate 200	c. Location - City or To	own, State
iim	Pag ment tant: I		Medical	Center 200	5 Wa	ashington,	
Ball	permit Depart Impor any in		Chitz Saroh	22. Name and Address of Facility Col P.O. Box 58	007 Washi	ington, D.	vices, Inc. C. 20037
			23a. Part1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.	,		3150-55	Approximate Interval Between Onset and Death
	Physician / /Medical	0 1	Immediate Cause (Final disease or condition resulting in death)  A. Due to (or as a consequence of):	nix Cravis			3 weeks
	Examiner		myasthe	nix Graves			
	ed isit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
Ć,	execut n and ial-trar	Examiner	that initiated events resulting in death) Last C				
8760,	cate be executed physician and the burial-transit		d				
Box 6	death certificate be executed e attending physician and of for use as the burial-transii	л/Мес	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of deliv	erv
.O. BQ		Physician/Medical	in the past 12 months?	□Ectopic pregnancy □ Other (specify)		Month	Day Year
<u>α</u>	requires that the een signed by th hould be detache		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	co use contribute to t	he cause of death?
ord	w requires that s been signed b should be det	ted	& fellensern. Hagia.	racemaker	1 ☐ Yes	2 ☐No 3 ☐ Prot	bably 4 Unknown
of Vital Records,	has le 2	Completed by	J's cificiency to nor	mel	24a. Was an autopsy performed	prior to co	opsy findings available empletion of cause of
tal		a	25. Was case referred o medical	26. Place of Death	1 ☐ Yes 2 🗹	No 1 ☐ Yes	2 No
ίV	dis y	To B	examiner? 1   Yes 2   No   Hospital: 1   Inpatient 2   ER/Outpatie	04	`	e 6 □Other (Specif	fy)
0 00	ding Ph h. After thi funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) Injury Injury	Work?	8d. Describe how i	njury occurred	
Division	Attanding r death. actor: After by the funer	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s	M 1 ☐ Yes 2 ☐ No  treet, factory, office 2	8f. Location (Street	t and Number or Rura	al Route Number.
Ö	s after s after al Dira	Certification;	4 ☐ Homicide determined building, etc. (Specify)		City or Town, S	tate)	
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical	29a. Certifier  (Check only one)  1	th occurred at the time, date and place, and nvestigation, in my opinion, death occurre	nd due to the cause od at the time, date	e(s) and manner as s and place, and due to	stated. o the cause(s)
	withi To t	Σ	29b. Signature and title of certifier	29c. License number		Date signed (Month,	,
			30. Name and address of person who completed cause of death (Item 23a) (Type	W 20412		rarch	1,4005
			30. Name and address of person who completed cause of death (item 23a) (Type III S (148 AC 4 11) (14	1). Print) 20, Russe 1). Garthers	courg	Mada	0877
	Sta Registr		MAR 11 2005	arti	V		

		,	Please I  1 - State Registrer	State of Maryl	and / Dep		lealth and I	Mental Hygi	•	10246
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Arthur John Boyle					2. Date of Death Month March 7,	Day Year	3. Time of Death 1:00 P M
	Examin Funeral Director		4a. Facility Name (If not institution, give s Holy Cross Hospit 5. Social Security Number 134-24-0684 6. Sex	al	yrs. last birthday) 2 Yrs.		Spring  If Under 24 Hrs. Hours Min.		rear) Co	
	se maryland Ba-f show	ector	Usuel Residence of Decedent  10a. State 10b. County  Maryland Montgo		City, Town or Lo	er Spring				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	illed within 72 hours after death with the Maryland Hygiene. Hydiene." nature!", or Items 23a or 28a-f show ant, it e Madical Evarial et mast be notified.	Funeral Director	9900 Georgia Ave	2. Was Decedent Ever	in U.S. 13.	10f. Zip Code 20902 Was Decedent of H If Yes, specify Cuba			USA  14. Race - Ame Black, Whit	erican Indian,
0000	72 nours alle naturel', or It	by	1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Educ (Specify only highest grade	ation	57-61   16a. Dece	1 ☐ Yes 2 ☑ No	Specify:	10	Specify: Whi	te
1717 N	Hygiene.  therefore then "a ant, II amo	e Completed	Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Last)	College (1-4or 5+) 4	life.	DO NOT use retired puter Man	agement	ne (First, Middle, Ma	Compute:	r
lar yla	12 should be h and Mental 7 is marked o reumatic eve	To Be	James Boyle  19a. Informant's Name/Relationship (Ty)				and Number or Ru		City or Town, State, 2	
	permit. Pages 1 and 2 should be tiled within 72 hours atter death with the Marylan Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  By nitrorent: If them 27 is marked other then "naturel", or Items 23a or 28a-f show any nitrorent interpretation of the Maryland Examiner must be notified at once.		Mary V. Boyle/ wi  20a. Method of Disposition  1  Burial 2 □ Cremation 3 □ R  '4 □ Donation 5 □ Other (Specify)	emoval from State	b. Place of Dispo cemetery, cre		ов) Mar	ch 10	pring, MD c. Location - City or Llver Spri	
Dall	permit. Departe Importe any inj	2.51	21. Signature of Funeral Service License  23a. Part1. Enter the disease, or comblishock, or heart failure. List only on	Cole	5	00 Univer	sity Blv		ver Sprin	g, MD 20901 Approximate Interval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Bleeding Due to (or as a cor	Duodena	l Ulcer				Onset and Death 6 Days
,007	ate be executed hysician and the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underling Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cor	sequence of):	Cancer				1 Year
O. DOY 00	Ine law requires mat the death certificate ite has been signed by the attending phys bage 2 should be detached for use as the	Physiclan/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	Bc. If yes, outcome of pre 1 Live birth 2 1 4 Pregnant at time 9 Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)	,		23d. Date of del Month	ivery Day Year
JI (P)	w requires that the de been signed by the a should be detached	by	Part II. Other significant conditions con	tributing to death but not	t resulting in the u	underlying cause giv	en in Part I.		cco use contribute to	the cause of death?
ומו שבר	sicien: The law r s certificate has be lirector, page 2 sh	e Completed	25. Was case referred to medical				00 514 5	24a. Was an autopsy performe	prior to death? ⊠ No 1 □ Yes	atopsy findings available completion of cause of
	ng Pny fter this	To B	eyaminer?	ospital: 1 Mnpatient 28a. Date of Injury (Month, Day Yea	2 ER/Outpatier 28b. Time o Injury	of 28c. Injur Wor	er: 4 ☐ Nursing H	ome 5 Residen 28d. Describe how	ce 6 □Other (Spe	city)
	To the Hospitel of Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the to	I Certification:	3 Suicide 4 Homicide  6 Could not be determined	28e. Place of Injury - building, etc. (Spicien: To the best of my	pecify)			City or Town,		
	o the Hos vithin 24 h o the Fun completely	Medical		er: On the basis of exar and manner stated.			pinion, death occu	rred at the time, dat		to the cause(s)
	15+1		30. Name and address of person who co	mpleted cause of death		D35	162		March 7,	2005
	Sta	ite	Michael Schindle 31. Date filed (Month, Day, Year)	r, M.D. 10	801 Loc	wood Dri	ve, Silve	er Spring,	MD 20901	
	Registr		MAR 11 200	32 Registrar's S	K A	all?				

DHMH 17 Rev 1/2001

		1 - State Registrar			artment of I			Reg. No. 2	INS	_1001	
Physicia /Medic		Decedent's Name (First, Middle, La VIVIAN	SULLIVAN		BR	ADY	2. Date of De. March	7, Day 200	OŠ <sup>ear</sup>	3. Time of Death 12:30P.	
Examin		4a. Facility Name (If not institution, given 4210 Howard Road	ve street and number)	4b. City, Town, o Beltsv.	_	4c. County of Death Prince George's					
Funeral Director			Sex 7. Age (In yrs. 1 ☐ M 2 💢 F	75 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day NOV. 2	1929	9. Birthp Cour Mar	lace (State or Forei stry) yland	
a-f show	ctor	10a. State 10b. County		ty, Town or Lo					1	0d. Inside City Limit	
23a or 28	Funeral Director	10e. Street and Number 4210 Howard Road			10f. Zip Code	20705		10g. Citizen of V United			
2 -	by	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hilf Yes, specify Cubin	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- Rican, etc.)	14. Rac Blac Specify	e - Americ ck, White,		
than the Me	Completed	15. Decedent's E (Specify only highest grant properties) (9-14) 2	ducation ade completed)  College (1-4or 5+)	dent's Usual Occupation kind of work done during most of working DO NOT use retired) SS Maker			16b. Kind of Bi		dustry		
othe vent,	To Be C	17. Father's Name (First, Middle, Last George	Sulli	van		18. Mother's Nam Chlora	ne (First, Middle,	Maiden Sumame) Pierce			
alth and 27 is ma		Jeffrey P. Brady	Туре, Print) —SON	19b. Mailir <b>421</b> 0	ng Address <i>(Street</i> Howard F	a <i>nd Number or R</i> u Road Belt	ral Route Numbe sville,	r, City or Town, Marylan	State, Zip ad 207	<sub>Соде)</sub> 705	
orthern of Health and Menta orthern of Health and Menta orther If Item 27 is marked injury or other traumatic e		20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Special	Removal from State Met	Place of Disponentery, cremetery, remeter, cremeter,	sition (Name of matory or other place tan Crema	itory 3/8	Date /2005	<sup>20c.</sup> Location - Alexand	_	wn, State Virginia	
Departm Importa any inju		21. Signature of Funeral Service Licer	Bogwardt	4	Name and Address Onald V. 400 Powde	r Mill R	oad Belt	sville.	PA Mary	rland 207	
nysician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	Metastatic	Lung	er the mode of dyin	g, such as cardiac	or respiratory arr	est,		Approximate Interval Between Onset and Death	
xaminer	-E-	er		Due to (or as a conseq							
	ē	Sequentially list conditions,			ary Metas	tasis					
and I-transit	xaminer	Sequentially list conditions, any based of conditions of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Liver Meta	stasis	ary Metas	tasis					
nysicia he bu	ical Ex	cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a suriseq	usned of): stasis uence of):	ary Metas	tasis					
e attending physicis of for use as the bu	cal	cause. Enter Underlying Cause (Disease or injury that initiated events	Liver Meta c. Due to (or as a conseq	usnes of): stasis uence of): tasis	ary Metas  Ectopic pregnancy Other (specify)	tasis		23d. Date Mor	e of deliver	y Day Year	
e attending physicis of for use as the bu	by Physiclan/Medical	Lary technical and the cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	c. Due to (or as a conteq  Liver Meta  Due to (or as a conseq  Bone Metas  d. 23c. If yes, outcome of pregna    Live birth 2   Feta  4   Pregnant at time of de  9   Unknown	uence of): stasis uence of): tasis uncy I death 3 eath 5	Ectopic pregnancy Other (specify)			Mor	ibute to the	Day Year	
tte has been signed by the attending physicit page 2 should be detached for use as the bu	Completed by Physician/Medical	ary, teeding to find a single cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  Part II. Other significant conditions of	c. Due to (or as a conteq  Liver Meta  Due to (or as a conseq  Bone Metas  d. 23c. If yes, outcome of pregna    Live birth 2   Feta  4   Pregnant at time of de  9   Unknown	uence of): stasis uence of): tasis uncy I death 3 eath 5	Ectopic pregnancy Other (specify)		1 ☐ Ye	Mor pacco use contr ps 2 \( \text{No} \)	ibute to the	o cause of death?  bly 4 XUnknow  sy findings available pletion of cause of	
his certificate has been signed by the attending physiciful director, page 2 should be detached for use as the bu	To Be Completed by Physiclan/Medical	ary, teen to fine a state of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  Part II. Other significant conditions of examiner? 1 □ Yes 2 □ No 27. Manner of Death	Liver Meta  C. Due to (or as a conseq Bone Metas  d. 23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of de 9 Unknown  contributing to death but not resi	uence of): stasis uence of): tasis uncy I death 3 = eath 5 = ulting in the ur	Ectopic pregnancy Other (specify)  Identifying cause give	an in Part I.  26. Place of Deat  if: 4 □ Nursing Ho  at	1 Yes 24a. Was a autops perform 1 Yes 2	More pacco use controls 2 No P P P P P P P P P P P P P P P P P P	ibute to the 3 Proba Vere autoprior to comeath? Ves 2	o cause of death?  bly 4 XUnknow  sy findings available pletion of cause of	
after death.  Director: After this certificate has been signed by the attending physicit in by the funeral director, page 2 should be detached for use as the bu	To Be Completed by Physiclan/Medical	ary, seeing to finite cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  Part II. Other significant conditions of examiner? 1 □ Yes 2 □ No	Liver Meta  C. Due to (or as a conseq Bone Metas  d. 23c. If yes, outcome of pregna 1	uence off: stasis uence of): tasis uncy I death 3 =	DEctopic pregnancy Other (specify)  Inderlying cause give  Standard DOA  28c. Injury Work M 1	an in Part I.  26. Place of Deat  if: 4 □ Nursing Ho  at	24a. Was a autops perform 1 Yes 2 th (Check only on me 5 Reside	Mor  pacco use contr  ps 2  No  n 24b. V  p 2  pacco use contr  ps 2  No  n 24b. V  p 2  pacco use contr  ps 2  No  n 24b. V  pacco d  pacco use contr  ps 2  No  n 24b. V  pacco d  pa	ibute to the 3 Proba Vere autoprior to come ath? Yes 2	Pay Year  Pay a cause of death?  Pay a tage of the cause	
after death.  Director: After this certificate has been signed by the attending physicit in by the funeral director, page 2 should be detached for use as the bu	Certification: To Be Completed by Physician/Medical	ary, teering to find a cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Liver Meta  C. Due to (or as a conseq Bone Metas  d. 23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown  contributing to death but not resi	stasis uence of): tasis uncy I death 3 eath 5 ulting in the ur  EP/Outpatient 28b. Time of Injury une, farm, stre	DEctopic pregnancy Other (specify)  Identifying cause give  28c. Injury Work M 1 1	26. Place of Deat  26. Place of Deat  4 □ Nursing Ho  at  ?  (es 2 □ No	24a. Was a autops perform 1 Yes 2 h (Check only on me 5 N Reside 28d. Describe ho	Mor  pacco use contr  ps 2  No  1  24b. V  p  d  CM No 1  pnce 6  Othe  w injury occurre  reet and Number  state)	ibute to the 3 Proba Vere autoprior to comeath? Pres 2  or (Specify)	Poute Number,	
in 24 hours after death.  The Funeral Director: After this certificate has been signed by the attending physicit pletely filled in by the funeral director, page 2 should be detached for use as the but the funeral director, page 2 should be detached for use as the but the but the but the funeral director.	ledical Certification; To Be Completed by Physician/Medical	25. Was case referred to medical examiner?  1 Yes 2 No 9 Unknown  27. Manner of Death 1 Astural 5 Pending investigation 3 Suicide 4 Homicide  29a. Certifier (Check only 2 Madical Exam	Liver Meta  Liver Meta  Due to (or as a conseq  Bone Metas  d.  23c. If yes, outcome of pregna 1	stasis uence of): tasis uncy I death 3 eath 5 ulting in the ur  EP/Outpatient 28b. Time of Injury une, farm, stre	DEctopic pregnancy Other (specify)  Identifying cause give  28c. Injury Work M 1 1	an in Part I.  26. Place of Deat  37. 4 □ Nursing Ho at ? (es 2 □ No e, date and place, inion, death occurr	24a. Was a autops perform 1 Yes 2 h (Check only on me 5 N Reside 28d. Describe ho 28f. Location (St. City or Town and due to the cared at the time, day	Mor  pacco use contr  ps 2  No  1  24b. V  p  d  CM No 1  pnce 6  Othe  w injury occurre  reet and Number  state)	ibute to the 3 Proba Vere autoprior to comeath? Pres 2 or (Specify) or or Rural or or Rural (Month, Di	Day Year  a cause of death?  bly 4 Munknowr  sy findings available pletion of cause of  I No  Route Number,  ted.  the cause(s)  ay, Year)	

			1- For State of Maryland / Department of Health and Certificate of Death		giene	5 102	248
	<b>5</b> 1		Decedent's Name (First, Middle, Last)	2. Date of Dea Month	ith Day	Year 3. Time	of Death
	Physici /Medi		ARTHUR S. BRAXTON		8, 200		L8 M
	Examir		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Dea	th	4c. County		
			Shady Grove Adventist Hospital Rockvill	е	MON	TGOMERY	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Norths Days Hours Min	8. Date of Birth	Yearh -	9. Birthplace (State	-
	Director		218-05-0222 15 W 2	Apr. 5	,1919	Wash. I	)C
	pue *		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside (	City Limits
	fanyla sho	5	MD Montgomery Rockville				s 2 No
	28a-1	Director			10- 011	Λ	
	with a or		10e. Street and Number 102 Fallsgrove Blvd, #1109 20850		10g. Citizen of W	S.A.	
	rs after death with the Marylan ', or Items 23a or 28a-f show saminer must be notified at	Funerai		Spacify Vac or No-		- American Indian.	
	iter d	E	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married  12. Was Decedent of Hispanic Origin? (Same Forces) If Yes, specify Cuban, Mexican, Puer	to Rican, etc.)		, White, etc.	
360	urs a	þ	XXWidowed 4 □ Divorced If Yes, Give Year or Dates: 43-45 1 □ Yes 2 ☑ No Specify:		Specify:	Black	
21215-0036	72 hours after death with the Maryland 'natural', or Items 23a or 28a-f show dical Examiner must be notified at	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of Bus	siness/Industry	
2	S 63	pje	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  (Give kind of work done during most of wo	nking			
2	TI CO	20	7th Animal Technici	an	N.I	.H	
pu	8 E 9 8	Be (	17. Father's Name (First, Middle, Last)  18. Mother's Na	me (First, Middle,	Maiden Sumame	ı)	
Va		2		nie Mar			
Maryland	A DE E		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or R			/	0850
	is 1 and 2 should to Health and Mer item 27 Is marke other traumatic		James R. Campbell (Nephew) 102 Fallsgrove B	The second second			MD,
altimore,	Pages 1 and Indian It is or other		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place)			City or Town, State	
Ē	artment ortent: injury o		4 Donation 5 Other (Specify)	6,2005	Gaith	ersburg,	MD
Ball	permit. Pages Department of I Importent: If its any injury or of		21. Sig later of Funeral Service Tense e				
_	40 = 4 d		plonger, monden p. 146 N. Wash. S			, MD 208	50
			23a. Part1. Enter the disease, or complications that caused the death. To not enter the mode of dying, such as cardia shock, or heart ailure. List only one cause on each line.	c or respiratory arr	est,	Approxima Interval Be	tween
	Priysician		Immediate Cause (Final disease or conditiona Acute Myocarchal Infarc	tion		MINU:	1
1	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Acute Myocarchial Infance Due to (or as a consequence of):  Covonary Ateny Disease	,			
	_xammor	L	Sequentially list conditions h Coronary Hery Disease			yea	u
	ed sit	ine	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			•	
	kecut and I-tran	Examin	that initiated events resulting in death) Last  Due to (or as a consequence of):				
8760,	be executed sician and burial-transit	ie H					
687	ate he	edicai	d		<del></del>		
×	eath certific attending pl	ian/Me	IF FEMALE: 23c. If yes, outcome of pregnancy		004 D-4-	-4 deline-	
Вох	atten for u	cian	in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy		23g. Date Mont	of delivery th Day	Year
o.	at the de by the a tached	Physici	1 Yes 2 No 9 Unknown 9 Unknown				
<u>α</u>	res that igned b be deta		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tot	pacco use contrib	oute to the cause of	death?
sp.	uires sigr ld be	d by	Chronic Renal Insufficiency	1 🗆 Ye	s 2×No 3	B Probably 4	Unknown
of Vital Records,	w requir been si should	Completed	Prostate Cancer	24a. Was a	n 24h W	ere autopsy findings	ovoljeble
Re	The lavate has	m d	THE CANCEL	autops	y pr	ior to completion of coath?	
a		CO	25. Was case referred to medical 26. Place of De-			☐Yes 2☐ No	
⋚	ysician: is certific director,	o B	examiner?	ath <i>Check onl</i> on Iome 5□ Reside		(0 (1)	-
ō		<del> </del>	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	28d. Describe ho			
on	tending Ph death. tor: After th the funeral	tio	1X Natural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No				
Division	l or Attendl after death. Diractor: A in by the fu	ifica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office	28f. Location (St.	reet and Number	r or Rural Route Num	nber,
ā	el or A s after il Dira	Certification:	4 Homicide building, etc. (Specify)	City or Town	n, State)		
	To the Hospitel or At within 24 hours after o To the Funeral Dirac' completely filled in by		29a. Certifier  (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death accurate	and due to the ca	ause(s) and man	ner as stated.	
	he H in 24 he Fi	edicai	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurrence and manner stated.	irred at the time, da	ate and place, an	d due to the cause(s	s)
	To the P within 2 To the F complete	Ň	29b. Signature and title of certifier 29c. License number			(Month, Day, Year)	
	1		Vamara Kile & H0051791	1	larch	8,2005	5
	>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	7	. 1		
			Tamara L. Kik, D.O. 9901 Mcdical Center Drive	, Kockvi	The MD	90820	
	Sta		31. Date filed (Month, Day, Year) MAR 1 1 2005  32 Registrar's Signature				
	Registr	ar	HILLIN II T COOL				

	. 4		1- For Amend Item #27 State of Maryland / Department of Health and State Registrar WCHD/SH 3/16/05 per DR Certificate of Death	Mental Hyg	_	10249	
}	Physici /Medic Examin	al	1. Decedent's Name (First, Middle, Last)  Martin W Doill  4ayFacility Name (If not institution, give street and number)  4b. City/Town, or Location of Decedent's Name (If not institution, give street and number)	2. Date of Deal Month March ath	Day Year 7 200	5 6:32 PM	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)   If Under 1 Year   If Under 24 Hi   232-28-2037   1 May 2 F   88   Yrs.   Months   Days   Hours   Min   Usual Residence of Decedent		916 WE	irthplace (State or Foreign Sountry) STVIRGINIA	
	h the Maryland r 28a-f show	irector	10a. State   10b. County   10c. City, Town or Location	1	0g. Citizen of What (	10d. Inside City Limits X Yes 2 □ No Country?	
36	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or terma 23a or 28a-f show event, I'm Medical Exart, at must be notified at	by Funeral Director	210 SPRUCE STREET  25401  11. Marital Status  1  Never Married 2 Married  1  Never Married 2 Married  3  Widowed 4 Divorced  25401  12. Was Decedent Ever in U.S. Armed Forces? 1  Yes 2 No If Yes, Give Year or Dates: 1 Yes 2 No Specify:	(Specify Yes or No- erto Rican, etc.)	USA  14. Race - Am Black, Wh  Specify:		
21215-0036	filed within 72 hou Hygiene. ther then "neture int, I'm Medical	Completed I	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  8  16a. Decedent's Usual Occupation (Give kind of work done during most of work of the DO NOT use retired) SHIPPING SUPERVISOR	vorking	16b. Kind of Busines NATIONAL F (FRUIT PACK	s/Industry	
Maryland	should be filed nd Mental Hygi marked other imatic event, I	To Be (	17. Father's Name (First, Middle, Last)  18. Mother's N.	ame (First, Middle, MIAN MILLE!	R	Zin Code)	
	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic enones.			KENNETH W. BRILL/SON  210 SPRUCE STREET,  20a. Method of Disposition  1X Burial 2 Cremation 3 Demoval from State  MARC	MARTINSBU		401 or Town, State
Baltimore,	permit. P Departme Importar any Injur		21. Signature of Funeral Service Licensee  Chaeles M. Brown  22. Name and Address of Facility BROWN FUNERAL HOME, I MARTIN	P.O. BOX 821 NSBURG, WV 2	327 W. KIN 5402	NG ST.,	
8760,	death certificate be executed  WEXA  We attending physician and dor use as the burial-transit	icai Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardinated cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Ente, Underlying Cause. (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C. Lather Fracture  Due to (or as a consequence of):  C. Lather Fracture  Due to (or as a consequence of):  C. Lather Fracture  Due to (or as a consequence of):  C. Lather Fracture  Due to (or as a consequence of):	ac or respiratory arre	est,	Approximate Interval Batween Onset and Death  20 days  13 days	
P.O. Box 68	death certific e attending p od for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date of de Month	elivery Day Year	
ecords, P.	law requires that the de as been signed by the a 2 should be detached f	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	/	to the cause of death?  Probably 4 □Unknown	
Vital Rec	The ate h page	Certification; To Be Completed	© 25. Was case referred to medical 26. Place of De	24a. Was ar autopsy perform 1 Yes 2	y prior to ned? death? LDNo 1 ☐ Ye	autopsy findings available completion of cause of	
Division of	ding Phys T. After this funeral dii		examiner?  1 Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other: 4 Nursing		nce 6 □Other (Spa w injury occurred	ocify)  Sural Route Number.  J. C. A.S. F. C. Av.	
	To the Hospital or Attand within 24 hours after death To the Funeral Director: completely filled in by the	Medical (		curred at the time, da	ausels) and manner a the and place, and du ad. Date signed (Mon	s stated. e to the cause(s)	
51	-3+/ Sta Regístr	te ar	30. Name and address of belson who completed cause of death (Item 23a) (Type, Print)  Double of Death of M.D. 10NO Regula Street  31. Date filed (Month, Pay, Year)  32. Registrar's Signature	BALTIMUR	211105 24 MD L	1201	

		_	1 - For State Registrar	State of M	aryland		artmen rtificat			and M	lental Hy	giene	005	<b>.</b>	0250									
	Physic /Medi		1. Decedent's Name (First, Middle, L. Kathleen Elizab		r						2. Date of De Month MARCH	eath Da		ar 55	3. Time of Death									
	Exami		4a. Facility Name (If not institution, gi Washington Coun				4b. City, Town, or Location of Death Hagerstown					4c. County of Death Washington												
	Funeral Director			Sex 7. Ag 1 □ M 2 🖾 F	ge (In yrs. Iast 86	birthday) Yrs.	If Under Months		If Under 2 Hours	Min.	8. Date of Bir (Month, Da 11/17/	th ly, Year, 1918	9.	Birthpl Count	ace (State or Foreig try) PA									
	Naryland	ctor	MD Washing	ton	10c. City, T Hag	own or Lo								10	od. Inside City Limits									
	th with the 23a or 2	Funeral Director	10e. Street and Number 9927 Premier Vi	ew Circle			10f. Zip	740				10g. Ci	tizen of What	t Count	ry?									
900	d within 72 hours after death with the Maryland jiene. r than "netural", or Items 23a or 28a-f show Itia Madisal Examinar must be froithed ut	by	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:			Was Deced if Yes, spec 1 ☐ Yes 2	_	spanic Orig n, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)	-	14. Race - A Black, V Specify:		tc.									
21215-0	within iene. than "	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 10			(Give	dent's Usua kind of wor DO NOT us	rk done d	lurina most	of worki	ing		ind of Busine Restau		,									
yland;	be filed ital Hyg id othe event,	To Be C	17. Father's Name (First, Middle, Las. Arthur (unk) Pl	ack					Ire	ne (	(First, Middle, unk) Wa	Maiden 111a	Sumame) CE											
, Mar	is 1 and 2 sh of Health and item 27 is n other treum		Nancy J. Humber		ter	9b. Mailir 9927	Prem	(Street a	View (	r or Aura Circ	le, Hag	er, City o	r Town, Stat town M	ө, <i>Zip (</i> D 2	20de) 1740									
	permit. Pages 1 and 2 should Department of Health and Mer Importent: If item 27 is marke any injury or other treumetic 2005.		20a. Method of Disposition  1 □ Burial 2 ③Cremation 3 □  '4 □ Donation 5 □ Other (Speci	(y)	ceme	hsbu 22	2. Name and	ther place emate d Addres	or. 0.	3/15 Ge	/2005 rald N. et, Hag	Smi Mi	nnich	g, Fun	MD eral Home									
	Physician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a PNEU	ne.	o not ent									Approximate nterval Between Onset and Death									
	icate be executed XX physician and image in burial-transit and in a	Completed by Physician/Medical Examiner	nysician/Medicai Examiner	hysician/Medicai Examiner	hysician/Medical Examiner	hysician/Medicai	hysician/Medicai Examiner	icai Examiner	icai Examiner	icai Examiner	cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. CKnow Due to (or as	a consequence	CTAU:	c Ti v =	- p.	V ~ 4 6.	N44	216	GHS	•		r ears
Box 6	death certif e attending d for use a							IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ ₩6 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal dea		Ectopic pre						23d. Date of o		∕ ay Year				
	quires tha on signed l uld be det		Part II. Other significant conditions of			in the ur	nderlying ca	use give	n in Part I.			_			cause of death?									
	: The law requires that the sate has been signed by the page 2 should be detache		CONGESTIV	F KSAA	FA	(0)	15				24a. Was a autop perfor	sv	prior t death	o comp	y findings available bletion of cause of									
VIE	sicien: Th certificate lirector, pag	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No	Hospital:	0 TED#			Othe			(Check only or		20											
ion or	To the Hospitel or Attending Physicien: The within 24 Hours atter death.  To the Funerel Director: After this certificate his completely filled in by the funeral director, page	-1	27. Manner of Death  1 Death  2 Accident  5 Pending  investigatio	28a. Date of Inju (Month, Day	v 28b	. Time of Injury		c. Injury Work	4 🗀 (40)3	2	ne 5□ Resid 8d. Describe h			oecify)										
DIVID	vitel or Attenors after death	Certification;	3 Suicide 6 Could not be determined	building, et	c. (Specify)						8f. Location (S City or Tow	n, State)												
	To the Hospitel within 24 hours a To the Funerel ( completely filled	edicai	29a. Certifier 1 Certifying Pt (Check only one) 2 Medical Exar	ysician: To the best on niner: On the basis of and manner sta	examination a	ge, death and/or inv	occurred a estigation, i	t the time in my opi	e, date and nion, death	place, a occurre	nd due to the o d at the time, o	ause(s) late and	and manner place, and d	as state	ed. ne cause(s)									
	To the within 2 To the comple	Σ	29b. Signature and title of certifier					License			2		signed (Mo.		y, Year)									
			30. Name and address of person who	completed cause of d	eath (Item 23a	) (Type, I		001	040			03	-/3-0	5										
101	1-7			32.2 6. ANT. 32. Registre			,	F Ks -	TOW	بد رب	0 21	740												
10	Sta Registr	i.e	MAR 15 2	005 Sz. Registra	a Signature	do	celle																	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State
Registrar amended item #12/3-14-05/wclad/tilipate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month 3 **Physician** illiam Year Burleson 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Coastal Hospice by the Lake Salisbury Wicomico If Under 1 Year If Under 24 Hrs. 8 Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Birthplace (State or Foreign Country) 1**⊠**M 2□F 246-72-9828 Director 59 Yrs. 7/7/1945 North Carolina Usual Residence of Decedent with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itams 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at once. 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits Maryland 1 ☐ Yes 2 No Directo Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 30562 Olde Fruitland Rd. 21804 USA 12. Was Decedent Ever in U.S. Armed Porces? 1 (T/Yes - 210 No If Yes, Give Year or Dates: Army 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 Yes 2X No þ Specify: 3 ☐ Widowed 4 ☐ Divorced white Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Wicomico County Board College (1-4or 5+) Elementary/Secondary (0-12) of Education 12 Assistant Principal 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Guy Burleson Mildred Whitley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30562 Olde Fruitland Rd., Salisbury, MD 21804 of Disposition (Name of Date 20c. Location - City or Town, State Wanda W. Burleson/wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 3/14/05 Salisbury, MD 22. Name and Address of Facility Holloway Funeral Home Professional Association CFSF 501 Snow Hill Rd., Salisbury, MD 21804 Jarro 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Metastatil one month /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician P.O. Box 68760 Physiclan/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 2 Fetal death in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 2 autopsy performed 1 Yes Hospital or Attanding Physician: 25. Was case referred to medical 26. Place of Death (Check only e) examiner' 1 Department 2 ER/Outpatient 3 DOA Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 🗌 Yes this 27. Manner of Death 28a. (ate of Injury (Month, Day Year) 28b. Time of Certification; 28d. Describe how injury occurred After Natural 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No within 24 hours after deatl To the Funaral Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29b Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

Saist MO

30. Name and address of person who completed cause death (Item 23a) (Type, Print)

0.0.

Bx 1733

32. Regilirar's Signature

(OLALL

31. Date filed (Month, Day, Year)

			1 - For State Registrar	State of Mai	-	partment of ertificate o		d Mental Hyg	giene	5 10050
			1. Decedent's Name (First, Middle, La	st)	1			2. Date of Dea	ith	3. Time of Death
	Physic		ERNE	ST Bel	MONT	.Tr.		Month	Day 2003	9er 05/4 M
}	/Medi Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town	, or Location of D		4c. County of	
			Peninsula legion	Nedical	Center	Sal	ishurd		Wicon	nim
	Funeral		5. Social Security Number 6. S	ex 7. Age	In yrs. last birthday	) If Under 1 Ye			9.	Birthplace (State or Foreign Country)
	Director		221-20-1298	<b>⊠</b> M 2□F	70 Yrs.	Months Day	s Hours N		- 34	Country) VA
	Jo		Usual Residence of Decedent							
	aryla 8hov	_	10a. State 10b. County		Oc. City, Town or I	ocation				10d. Inside City Limits
	89-f.	ct	DE JUSS	ex	Delb	yulle	/			1 XYes 2 No
	or 28	Sire	10e. Street and Number			J 10f. Zip Code	e		10g. Citizen of Wha	
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	r deg	Funeral Director	11. Marital Status	<ol> <li>Was Decedent Ev Amed Forces?</li> </ol>	er in U.S. 13	Was Decedent of	if Hispanic Origin' uban, Mexican, P	? (Specify Yes or No- uerto Rican, etc.)	14. Race -	American Indian, White, etc.
36	or II	by Fu	1 Never Married 2 Married	1 Yes 2 No		1□Yes 2		,	Specify:	D 1 - 11
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "netural", or Itams 23a or 28e-f show ther, the Modical Exertinat be mufflied at ant, the Modical Exertinat	D D	3 Widowed 4 Divorced	Year or Dates:	HKMI					DIACK
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12	withir one. than	Ę	Elementary/Secondary (0-12)	College (1-4or 5+)		ENERA		. 0 . 0	D. 11.	DINAT
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Ž	should be and Mental markad c	2	LENEST () 19a. Informant's Name/Relationship ()	selmon+	J/ .	C Add (01)		ULA F	TARMO	
Maryland	d 2 sho		Roll Al. Name/Adiationship		11 0	D Address (Stre	1	Rural Route Number	r, City or Town, Sta	te, Zip Code)
	1 and Health em 27 thar tr		20a. Method of Disposition	urns - OAUS	20b. Place of Disp	osition (Name of	3 Che		200 Leasting Cit	v as Tanas Chata
و	Pages nent of I int: If its		Burial 2 Cremation 3		cemetery, cre	ematory or other p	, I	11	20c. Location - City	y or Town, State
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygjene. Important: If item 27 is marked other than "netural", or Itams 23a or 28e-1 show any injury or other traumetic event, the Madical Exa. injury or other traumetic event, the Madical Exa. injury register be traillied at any injury or other traumetic.		`4 □ Donation □ Other (Specify		GOLDEN !	TCRES C	EM. 3	116/05	DECBY VIC	LE DE
Bal	permit. Departn Imports any inju	-	21. Signature of Fyneral Service Licen	500		22. Name and Add		J	SMITH	FIH
	442		200 Part Francis	2/20		117W. I	SABELLA	ST SAL	ISBURY, K	D 31801
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	/Medical Examiner		resulting in death)	Due to (or as a	consequenca of):	۹ نے ۱				
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	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Cua to (or as a c	ronsequance of):					
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8760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit			200 to (or 43 till)	onisoquentos on).					
87	phys the	dlcal		d						
9 ×	n certific inding p use as	Physician/Med	IF FEMALE:	23c. If yes, outcome of	prognancy					
Вох	ath certif attending tor use a	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2	Fetal death 3	Ectopic pregnar			23d. Date of Month	delivery Day Year
	at the de by the a tached	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at tin 9□ Unknown	ne or death 5	Other (specify)				,
P.0	hat ti		Part II. Other significant conditions of	ontributing to death but	of resulting in the	undarhina agus a	awas in Part I	22e Did to	22000 USA GOAtribut	te to the cause of death?
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ec	elaw hast je 2 s	Completed						24a. Was a autops	y prior	autopsy findings available to completion of cause of
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/ita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	11				Death Check only on	e)	
of	Physic this c	မ	IMPIES ZUNO	Hospital:	2 ER/Outpatie	III JU DOX		g Home 5 Reside	ence 6 Other (5	Specify)
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sio	tan leat tor: the	catl	2 Accident investigation 3 Suicide 6 Could not be	311100	190		Yes 2 No	Fall		
Division	l or Attand after death Director: , I in by the f	Certification;	4 Homicide determined	building, etc. (	Specify)	reet, factory, offic	е	City or Town	n, State)	Rural Route Number,
	urs a			Hospital				PRIME 1		oll St. Salishy
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edical	Check only 21 Style ICal Exam	ysician: To the best of a iner: On the basis of ex						r as stated. due to the cause(s)
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<b>\</b>	7 N D S	-	29b. Signature and title of celtifier			250. LICE	TOUG >	2:	9d. Date signed (M	onn, Day, rear)
7	~		30			17	13017/		3/11/05	
	11/4		30. Name and address of person who o	completed cause of deal	h (Item 23a) (Type	Print)	15 11	Hebers .	20	
	1,		Chils SNYACE,	D.111.12	Signatura	4	7 346	25 Usbury III		
	Sta	te ar	31. Date filed (Month Aak Year) 5	2005	CA HE	Leek ;				

State of Maryland / Department of Health and Mental Hygiene 11 = For State Registrar Certificate of Death 2. Date of Death 1 Decedent's Name (First, Middle, Last) <sup>Day</sup> 2005 **Physician** March 5, 12:45 A.N **Helen Epps** Co1e Renee /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Suburban Hospital Bethesda If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 1957 9. Birthplace (State or Foreign Country) New February 24, Brooklyn, York 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 X F 48 062-48-8587 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 28a-f show treumatic event, the Madical Examiner nest be notified at 1X Yes 2 □ No Director Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Numbe ŏ United States 13920 Castle Boulevard; Apt. 304 20904 Items 23a 72 hours after death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 □ Never Married 2 □ Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black 3 Widowed 4 Divorced "naturel", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 12 should be filed within 72 h and Mental Hygiene. 7 is marked other than "n College (1-4or 5+) Elementary/Secondary (0-12) **Insurance Company** 4 years Insurance Agent 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Milton Cammie **Epps** Deborah Esther Gentry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20877 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Importent: If item 27 is m any Injury or other treum once. 303 Bristol Downs Drive; Gaithersburg, Maryland Kisha Monique Cole (Daughter) March 14,2005 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Crematory, Inc. Beltsville, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility
R. N. Horton Company Morticians, Inc. 600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Adenocarcinoma of Unknown Primary 6 months **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, attending physician IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 No for 5 ☐ Other (specify) 4☐Pregnant at time of death the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an funeral director, page 2: autopsy performed? Yes 2X No 1 ☐ Yes 2 ☐ No 1 Yes To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1X Inpatient Cther: 10 1 Yes 2X No 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: After 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No after death. 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by determined 4 - Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

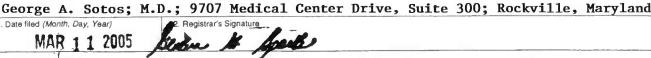
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medicai within 24 ho To the Fun completely i 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D43083 March 7, 2005

State Registrar

MAR 1 1 2005

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



DHMH 17 Rev 1/2001

20850

			1 - For State Registrar	State o	f Marylar		artmeni rtificate			d Mental Hy	giene Reg. No. 20 (	)5	10	254
	District in		1. Decedent's Name (First, Middle	, Last)						2. Date of De		/oor	3. Time o	f Death
	Physici /Medio			William A	lbert (	Cheadle				March	13, 200	5	3:05	а м
	Examir		4a. Facility Name (If not institution	, give street and nur	mber)		4b. City,	Town, or	Location of De	ath	4c. County of	Death		
_			Harford Me	morial Ho	spital			Havr	e de Gr			Harf	ford	
	Funeral		5. Social Security Number	6. Sex 1⊠M 2□F	7. Age (In yrs.		If Under Months		If Under 24 H Hours M	in. (Month, Da	th ay, Year)	Birthpla Count	ace (State ory)	o <i>r Foreig</i> n
	Director		215-16-5386 Usual Residence of Decedent	123 W. 2	82	Yrs.				June 2	28, 1922	Ma	rylan	<u> </u>
	land w		10a. State 10b. County		10c. C	ity, Town or Lo	cation					10	d. Inside C	ity Limits
1_	Mary - sh	ţ	Maryland C	ecil				Perr	yville					23 No
7,	r 28a	Director	10e. Street and Number				10f. Zip	Code			10g. Citizen of Wh	at Count	ry?	
	death with the Maryland ms 23a or 28a-f show rmust be rolified at	al D	283 Jackson St	ation Roa	d				21903		U.	S.A.		
000	deatl	Funeral	11. Marital Status	12. Was Dece Armed Fo	edent Ever in U	J.S. 13.	Nas Deced	lent of Hi	spanic Origin?	(Specify Yes or No erto Rican, etc.)	)- 14. Race -			
	or Ite		1 Never Married 2 Marri	ed 1⊠Yes	2 🗌 No		Tes, spec 1 ☐ Yes 2			eno nican, etc.)		White, e	tc.	
4	5-0036 72 hours after natural; or its	d by	3 X Widowed 4 ☐ Divorced	Year or D	ates: WW	TT	10163 2	INO	зроспу.		Specify:	W]	nite	
	72 t	Completed	15. Decedent (Specify only highes	's Education t grade completed)		16a. Deced	lent's Usua kind of wor	f Occupa k done d	ition <i>uri</i> ng most of w	vorking	16b. Kind of Busi Gore	ness/Indi	ustry	
Č	within than than than than than than than tha	d L	Elementary/Secondary (0-12) Eight Years	College (1	-4or 5+)				nagemen		Elkton,	Mary	vland	
5 5	Hygin Hygin ant,		17. Father's Name (First, Middle, I	Last)		Dul	Taing	, ridi			, Maiden Sumame)			
S.	re, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. If Health and Mental Hygiene. sitem 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic event, the Modical Examinal must be notified at	To Be	Willi	.am Walter	Chead	le					th George			
-	and Manual Manua	-	19a. Informant's Name/Relationsh	nip (Type, Print)		19b. Maifir	g Address	(Street a	-		er, City or Town, St		Code)	
	G, Ma 1 and 2 Health a Health a Health a		Susan M. Pattor	ı (Daught	er)	287 3	Tackso	on St	cation :	Road, Per	ryville,	MD	2190	3
/ -	Ore, N	l i	20a. Method of Disposition 1 □ Burial 2 ☒ Cremation	3 Pamoval from		Place of Dispo	sition (Nam	ne of ther place	9)	Date	20c. Location - Ci	ty or Tov	vn, State	
	altimo mit. Pag partment portant: I y injury o		'4 □Donation 5 □Other (Sp		R.	.A. Ferri	.s & Co	., In	oc. 03	/14/05	West Chest	er, I	Pennsyl	vania
ځ ک	Baltimor permit Pages Department of Filmportant: If ite any injury or of		21. Signature of Funeral Service I	icensee	DOK.	L	ee A.	Pat	s of Facility terson e, Mary	& Son Fu Land 219	neral Hom 03-0766	ne, I	P.A.	
5			23a, Part1. Enter the disease, or shock, or heart failure. List	complications that conly one cause on e	aused the dea ach line.	th. Do not ente	er the mode	e of dying	, such as card	iac or respiratory a	rrest,		Approximat Interval Bet	ween
	Physician		Immediate Cause (Final disease or condition	Cox	magas	y Ar	Len	ſ	Dite	ense		7	Onset and I	Seath
9	/Medical Examiner		resulting in death)	Due to (	or as a consec	querce of):	_	1					U	
9		-	Sequentially list conditions, if any, leading to immediate	b. — Due to (	or as a consec	mence of:								
ad	and is	ulu	Cause (Disease or injury			4-01100 0171								
0)	Bxecon and in and ial-tra	Examiner	that initiated events resulting in death) Last	C. Due to (	or as a consec	quence of):								
4	8760, cate be executed by sician and the burial-transit			d										
( )	ox 68 certifica nding ph	led		I										
	BOX aath cer attendin for use	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of pregnirth 2 Peta		Ectopic pre	onancy			23d. Date	of deliver	/	
	o death be atten ed for u	hysiclan/Medical	in the past 12 months?  1 Yes 2 No		ant at time of o		Other (spe				Month		ay 1	rear .
96	at the day the etache	Phy	9 Unknown											
2	cords, P.O. BOX 68 vequires that the death certific been signed by the attending p should be detached for use as i	by	Part II. Other significant conditio		eath but not res	sulting in the ur	iderlying ca	iuse give	n in Part I.		obacco use contribi			
8	w requir been si should	eted	(1)	1						. 10	Yes 2 No 3	Proba	bly 4 □l	Inknown
	25 8	Completed								24a. Was autor	osy prio	r to com	sy findings : pletion of c	available ause of
	OT VICAL KEOPhysician: The laveline certificate has all director, page 2									1 Tes		th? Yes 2	!□ No	
1 3	OT VITAL Physician: 1 this certifica	Be	25. Was case referred to medical examiner?	Hospital:				Othe		eath (Check only o	,			-
9	Phys rthis	. To	1 Yes 2 No 27. Manner of Death	1 100		ER/Outpatien 28b. Time of		-	4   Ivuising		dence 6 Other	(Specify)		
1 8	Ora ding h. Afte fune	tlon	1 Natural 5 Pending	,	of Injury h, Day Year)	Injury	М	Bc. Injury Work	a` es 2⊡No	Ecu. Describe	iow injury occurred			
10	OIVISION or Attending after death. Director: Afte in by the fune	flca	3 Suicide 6 Could n	ot be	of Injury - At h	ome, farm, stre				28f. Location (3	Street and Number	or Rural i	Route Num	ber.
<u> </u>	UIVISION Hospital or Attending 24 hours after death. Funeral Director: After	Certification:	4 🗀 Homicide determi	buildir	ng, etc. (Special	fy)	,			City or Tov	vn, State)			,
SX	papitu hours inera y fille		29a. Certifier Certifying	Physician: To the	best of my kno	owledge, death	occurred a	it the time	e, date and pla	ce, and due to the	cause(s) and mann	er as stat	ted.	
,	LIVISION OT VITAL KE TO THE HOSPICION OT VITAL TO THE HOSPICION: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical	(Check only 2 Medical E	xaminer: On the ba and mann	isis of examina ner stated.	ation and/or inv	estigation,	іп ту ор	nion, death oc	curred at the time,	date and place, and	due to t	he cause(s	
	Vithi To 1	Σ	29b. Signature and title of certifier		2		29c.	License	number		29d. Date signed (I	Month, Da	ay, Year)	
			1 lw me		ע״ע		1	1 -5	2600		3/13/	pcj	-	
	5+1VA		30. Name and address of person v	who completed caus	e of death (Iter	n 23a) (Type, I	(PAMI	المداد	Tim S	+ Haure	De lover	10	1 1 157	2
	Sta	te.	31. Date filed (Month, Day, Year)				1-000			Jew.	- minu(		(10/	)
	Registr	-	MAR 1 4 2005	Been 32. Re	& A	ade								

		1 - For State Registrar	State of Maryland / D	Department of F Certificate of	lealth and M		piene 2005	1025
Physicia /Medic	al	Decedent's Name (First, Middle, Last)     Philip Ricard Cram     4a. Facility Name (If not institution, give see	er	4b. City Town	or Location of Death	2. Date of Dea Month March	th Day Year 11 2005 4c. County of Deatt	3. Time of Death 12:20 A
Examin Funeral Director	er	Laurelwood Nursing 5. Social Security Number 6. Sex	Home 7. Age (In yrs. last birt	E1kton	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Oct.3, 1	Cecil 9. Birth	n nplace (State or Foreigr untry) nsylvania
e Maryland Ba-f show	ctor	Usual Residence of Decedent	10c. City, Town					10d. Inside City Limits 1 ☐ Yes 2 🛣 No
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, it e Madical Examinat must be notified at once.	by Funeral Director	10e. Street and Number  185 01d Log Cabin  11. Marital Status  1 Never Married  Married 3 Widowed 4 Divorced	Road  12. Was Decedent Ever in U.S. Armed Forces?  1  Yes, Give Yes, Give Year or Dates:	10f. Zip Code  21901  13. Was Decedent of It Yes, specify Cub  1 Yes 2X No		l	Jnited Stat  14. Race - Amel Black, White Specify: Wh	es rican Indian, a, etc.
d 2 should be filed within 72 hours aft th and Mental Hygiene. It and Mental Hygiene. 27 is marked other than "natural", or traumatic event, it e Mudical Exertiteaumatic	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12	College (1-4or 5+)	Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	during most of worki d)		16b. Kind of Business/	,
2 should be fill and Mental H Is marked oth raumatic even	To Be	17. Father's Name (First, Middle, Last)  Albert Cramer  19a. Informant's Name/Relationship (Ty)	pe, Print) 19b.	Mailing Address (Street	18. Mother's Name Jeanette and Number or Rura	Ricard	· · · · · · · · · · · · · · · · · · ·	lip Code)
nit. Pages 1 and artment of Health ortant: If item 27 injury or other tr		Betty Cramer/Wife  20a. Method of Disposition  1 XBurial 2 Cremation 3 R  4 Donation 5 Other (Specify)  21. Sign Visit Europal Service Census	emoval from State 20b. Place of cemeter North	Old Log Ca Disposition (Name of y, crematory or other pla East Method Cemetery 22. Name and Addre	ist Marcl	n 16,	20c. Location - City or	Town, State
Physician		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition	cations that caused the death. Do ne cause on each line.  PILEU MOI	127 South	Main Str	eet,Nort	h East,Mar	yland 2190 Approximate Interval Between Onset and Death
that the death certificate be executed:  Was ed by the attending physician and detached for use as the burial-transit	licai Examiner	cause. Enter Underlying	Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of Due to (or as a consequence of AWEMO SCLE	BS THEY  OF):	15ems6			5 Times  3 YEARS  2 YEARS
The law requires that the death certifica ate has been signed by the attending ph bage 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	y		23d. Date of deli- Month	very Day Year
w requires that I been signed by should be deta	by	Part II. Other significant conditions cor	ntributing to death but not resulting in	n the underlying cause gr	ven in Part I.		bacco use contribute to	
	e Completed	25. Was case referred to medical				24a. Was a autops perfor 1 Yes	med2 prior to death? 2. No 1 ☐ Yes	topsy findings available completion of cause of 2 No
ding Phys n. After this funeral di	To B	examiner?		Time of 28c. Injury Wo	-	me 5 Resid	ence 6 Other (Spec	cify)
or At fter c	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, fa building, etc. (Specify)			City or Tow		
To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical	one)	sician: To the best of my knowledge ner: On the basis of examination and and manner stated.	o, death occurred at the transfer investigation, in my of	me, date and place, opinion, death occurr	and due to the c ed at the time, o	ause(s) and manner as late and place, and due	stated. to the cause(s)
	M	29b. Signature and title of certifier  Lululch  30. Name and address of person who co			07463	2	Ped. Date signed (Month)  3 − ℓ ℓ − ℓ	
Sta Registr		Polando Najowa 1		ost Elleton	, Maryland	21921		

			1 - For State Registrar	State of I	Maryland / I		artment of tificate o				giene Reg. No.	005	10256
	Dharia		1. Decedent's Name (First, Middle, L	,						2. Date of De	ath Day	Year	3. Time of Death
	Physici /Medi		Donald Timot							Marc		2005	08:15A M
	Examir	ner	4a. Facility Name (If not institution, g				4b. City, Town		of Death			ounty of Death	
			121 Washingto 5. Social Security Number 6.		Age (In yrs. last bi	lade de . 1	Frost If Under 1 Yea		24 Hen			Allega	
	Funeral Director			Sex M 2□F		Yrs.	Months Day		Min.	8. Date of Bir (Month, Da			place (State or Foreign ntry)
			216-22-5184 Usual Residence of Decedent		76					11-Sep-	1928	Mary	land
	nylan how		10a. State 10b. County		10c. City, Tow	vn or Lo	cation					1	10d. Inside City Limits
	Se-f s	cto	Maryland Allega	any	Frostbur	g							1 X Yes 2 No
	or 2	Dire	10e. Street and Number 121 Was	shington Stree	t		10f. Zip Code	•			10g. Citize	en of What Cour	ntry?
	72 hours after death with the Maryland neturel', or Items 23a or 28e-f show disal Examiner rust be notified at	Funeral Director				1	21532-				U.S.A		
	Item Item	ŭn.	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Decede Armed Force 1 ☐ Yes 2 [	s?	13. \	Was Decedent of Yes, specify Cu	f Hispanic Ori Jban, Mexicar	igin? (Spe n, Puerto I	cify Yes or No Rican, etc.)	- 14	<ol> <li>Race - Americ Black, White,</li> </ol>	
336	urs af	by	3 XWidowed 4 □ Divorced	If Yes, Give Year or Date			I□Yes 212/N	lo Specify:			s	Specify:	
5-0036	2 hor	Completed	15. Decedent's		16a	. Deced	lent's Usual Occ	upation			16b. Kind	White dof Business/In	
2121	within 7 ene. then "r	ple	(Specify only highest g Elementary/Secondary (0-12)	College (1-4d	or 5+)	life. L	kind of work dor OO NOT use reti	ie auring mas ired)	it or workii	ng			
21	filed wi Hygien other th	Son	8	0	dr	iver						nt manufac	cturer
and	be fit ntal H od otf	Be	17. Father's Name (First, Middle, La.	st)				18. Mothe	er's Name	(First, Middle	Maiden S	'umame)	
Maryland	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Marylan Deperanent of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or items 23a or 28e-f show may injury or other treumatic event, the Macical Examinet must be notified at once.	2	Griffith Connor	Tree Sint				Cathe	rine A	1cKenzie			
Mai	d 2 sh th and 7 is rr treum		19a. Informant's Name/Relationship				nnifer Stre		i de Grandon			Town, State, Zip	
	1 and Healt em 2		Marty Connor  20a. Method of Disposition	son			sition (Name of natory or other p		Akror	) ate		110 ation - City or To	44313
2	ages int of t: If it		1 ☑ Burial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Spec		10			lace)	10.14	2005			
Baltimore,	ertme orten injur		21. Signature of Funeral Service Lig		Eckhart	-	e <b>tery</b> . Name and Add	Iress of Facilit		ar-2005	cknart	Ma	aryland
Ba	permit. Depertr Importe eny inju		John K	Huch	T				ionnesco.	ant Aria	Limonth	ourg, MD	21522
			23a. P.M. Enter the disease, or co	mplications that caus	sed the death. Do	not ente	er the mode of d	ying, such as	cardiac o	respiratory a	rest,	Jule IVID	Approximate
	Physician	V.V	Immediate Cause (Final		sclenatic			/		dise	عروف	- 4	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)		as a consequence		(. 0-100	n) Cola	· •	CCI			Tor years
н	Examiner		Sequentially list conditions	h									
	₽ ≃	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consequence	of):							
	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c									
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	E	rosuming in dodiny Edst	Due to (or a	as a consequence	of):							
87	physi the	dicai	•	d									
9 X	death certifica attending ph for use as the	Physician/Me	IF FEMALE:	23c. If yes, outcom	ne of pregnancy						00	d Data of dali-	
Вох	atten atten I for u	clan	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal death		Ectopic pregnan Other (specify)	псу			23	<ul> <li>d. Date of delive</li> <li>Month</li> </ul>	Day Year
o.	that the d ed by the detached	lysi	1 Yes 2 No 9 Unknown	9□ Unknown			, , ,						
Д,	res that igned to be deta	by P	Part II. Other significant conditions	contributing to death	n but not resulting i	in the ur	iderlying cause (	given in Part I.		23e. Did to	obacco use	contribute to the	ne cause of death?
rds	v require been sig should b									1 🗆 1	/es 2□	No 3 ☐ Prob	ably 4 Unknown
Records,	aw re	Completed								24a. Was	an :	24b. Were autor	psy findings available inpletion of cause of
Ä	The I	E								autor perfo 1 ☐ Yes	rmed?	death?	npletion of cause of 2□ No
Vital		Bec	25. Was case referred to medical examiner?					26. Place	of Death	(Check only o			20110
of V	ding Physicien:  After this certification funeral director,	2	1 ☐ Yes 2 ☐ 10	Hospital: 1 ☐ Inpa	atient 2 ER/Ou	utpatien	3 DOA C	)ther: 4 ☐ Nu	rsing Hom	ne 5 Hesio	lence 6 [	☐Other (Specify	1)
o u		on:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Ir (Month, I	njury 28b. Da <i>y Year)</i> I	Time of Injury	28c. In			8d. Describe h	ow injury o	occurred	
Division	Attending r death. sctor: After by the fune	Certification;	2 Accident investigati 3 Suicide 6 Could not	he				□Yes 2□					
Σ	I or Atteno after death Director: I in by the	III	4 Homicide determine	d 28e. Place of	Injury · At home, fa etc. (Specify)	arm, stre	et, factory, office	ө	2	8f. Location (S City or Tox	Street and I m, State)	Number or Rura	I Route Number,
	pital		29a, Certifier 1 Certifying F	Physician: Tolha ha	and the second section	n donth		4: 4-4	d =1======				
	To the Hospital or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	edical	(Check only 2 Medical Exe	Physicien: To the be eminer: On the basis and manner	of examination an	e, death id/or inv	estigation, in my	opinion, dea	th occurre	d at the time,	cause(s) ar date and pl	nd manner as st lace, and due to	ated. the cause(s)
	omple	Me	29b. Signature and title of certifier		/		29c. Lice	nse number			29d. Date s	signed (Month, L	Day, Year)
	/		) Ilila	y/20			0	81-71-1-	,		Marc	4 7,2	004
	6		30. Name and address of person who	o co eted cause o	f death (Item 23a)	(Туре, І	Print)	36766	-				
701	nos		Vikramadiv	a POONA	i, M.D.	91	14 Sets	N Dr.	Cun	berla	ud,	Maryla	nel 21502
	Sta	- 1	31. Date filed (Month, Day, Year)	32. Regis	strat s Signature								
U-	Registr	rar	MAR 08 2	005 In	eva A.	Con	ale						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month 03 Year Patricia Cramer Mary 22:15 05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL ALLEGANY HEART SACRED CUMBERLAND If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral**  Birthplace (State or Foreign Country) 1 □ M 2 🕏 F Yrs. 377-12-4337 86 **Director** 01/18/1919 Michigan Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "netural", or Items 23a or 28e-f show the Medical Experies must be notified at 1 Yes 2 □ No Director MD Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 29 N. Lee Street 21502 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ 3 ♥ Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within 7 h and Mental Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) 12 Unit Secretary State Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be Department of Health and Menta Important; If item 27 is marked eny Injury or other traumatic ev John Maloney Mary French 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brian E. Hirsch / son 10905 Thornwood Drive, Cumberland, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State ^ 4 □ Donation 5 □ Other (Specify) Cumberland Crematory 03/15/2005 Cumberland, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD alut 23a. Part1. Enter the disease, or complications that caused to death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PNEUMUNIA MULTILOSAR 6 DAYS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the attending physician and thed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Dav 4 Pregnant at time of death 5 Other (specify) n signed by the Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à DEMENTIA ALZHIEWEKS 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Be Completed peen JUINT 24b. Were autopsy findings available prior to completion of cause of death? DECENSEATIVE 24a. Was an certificate has autopsy performed? Yes 2 No After this certificate har funeral director, page 1 Yes 2□ No 1 Yes Hospitel or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Hospital: 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No after death Director: 2 Accident investigation filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel within 24 hours at To the Funeral C completely filled in 29a. Certifier 1 🖺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D42054 22 MARCH IS, 2005 30. Nor e and address of page 5 who completed cause of death (Item 23a) (Type, Print) nas DONALDSON 912 Seton Drive Comberland, NOD 21502 Dr. Gregg 22. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 1 5 2005

			1 - For State Registrar	State of Ma	arylan	•	artmen rtificate			and M		Reg. No.	200	[	Las	250
	Physici		Decedent's Name (First, Middle, Last     Irving (								2. Date of De Month March		005 Y	'ear	3. Time 6	roeath V
	/Medic Examir		4a. Facility Name (If not institution, give				4b. City,	Town, or	Location o	of Death	IMICII		County of	Death	10:50	J A W
			Mariner Health of	Silver S	pring	3	Si	lver	Spri	_		Mo	ontgo	mery	7	
	Funeral Director		5. Social Security Number 6. Se 577-12-0756	7. Ag	e (In yrs. I	ast birthday) Yrs.	If Under Months	1 Year Days	If Under: Hours	24 Hrs. Min.	8. Date of Bin (Month, Da Jan. 1	th y, Year) b, I	919	Birthpl Coun Mary	lace (State try) y Land	or Foreign
	yland sow		10a. State 10b. County		10c. City	, Town or Lo	cation							10	Od. Inside C	ity Limits
	e Mar Sa-f sl	ctor	Maryland Montgome	ry	F	Bethes	da								1 🗌 Yes	2√No
	with th	Director	10e. Street and Number				10f. Zip		0017			-	en of Wh		•	
	leath v	erai	6510 E. Halbert R	12 Was Decedent	Ever in 115	S 13 V	Was Deced		0817	ain? (Spe	noify Voc or No		ed S			
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show many injury of their traumatic event, the Medical Exarters must be notified at an once.	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1 Yes 2X  If Yes, Give  Year or Dates:	No	ļ l	fYes, spec		Specify:	girr (Spe i, Puerto	ecify Yes or No Rican, etc.)			White, e		
2-0	72 ho	Completed	15. Decedent's Edu (Specify only highest grad			16a. Decec	lent's Usua	l Occupa	tion	of worki	na	16b. Kin	nd of Busin	ness/Ind	lustry	
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d 2	filled v Hygie other t		17. Father's Name (First, Middle, Last)			0wn er	<u> </u>		18. Mothe	r's Name	(First, Middle,		luor	Stor	:e	
lan	Mental Mental rked o	To Be	Jacob Caplon								dlavit		Jumamey			
Maryland 21215-0036	aith and A aith and A 27 Is ma ar trauma		19a. Informant's Name/Relationship (T) Harriet Cobern, D			19b. Mailin 6510	g Address E. Ha	(Street a	nd Numbe rt Ro	or or Rura	Route Number Betheso	ar, City or la, M	Town, Sta	ate, Zip 0817		
Baltimore,	of He of He		20a. Method of Disposition 1 X Burial 2 Cremation 3 F	Removal from State	20b. PI	ace of Dispos	sition (Nam	e of her place	, 10	3/13	<del>7</del> 05	20c. Loc	ation - Cit	ty or Tov	wn, State	
E I	mit. Pages partment of portent: If it injury of		* 4 ☐ Donation 5 ☐ Other (Specify)		King	g David	i Memo	oria:	l Gar	den		Fal1	s Ch	urch	, VA	
Bai	permit Depar Impor any in		21. Signature of Funer Service Licens	88							uneral					
- Taller	Physician /Medical Examiner		23a. Part1 Effer the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	ications that caused ne cause on each line.  Pneumon  Due to (or as	ia	. Do not ente	o4 <u>Ca</u>	rro⊥. ∍ of dying	L St.	, NW cardiac o	, Washi	ingto	on, D		20012 Approximat Interval Bet Onset and Days	ween Death
38760,	icate be executed physician and s the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Lauss (Section 1997), that initiated events resulting in death) Last	Due to (or as  Due to (or as												
.O. Box 6	that the death certific ed by the attending p detached for use as	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3	Ectopic pre Other (spe					2:	3d. Date o Month		•	rear .
rds, P.	w requires that the been signed by th should be detache	ed by PI	Park II. Other significant conditions co	ntributing to death be	ut not resu	lting in the un	derlying ca	use give	n in Part I.						cause of d	
Vital Record	The law ate has b page 2 s	Complet									24a. Was autop perfor 1 Tes	sy	prio deal	r to com th?	sy findings a pletion of ca	available ause of
Vita	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	lospital:							(Check only or	-				
ot	Attending Phys or death. ector: After this by the funeral dir	tion: To	1 Yes 2 XNo   27. Manner of Death 1 XNatural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Da)	у :	R/Outpatient 28b. Time of Injury		c. Injury Work	4AL INUI	2	ne 5 ☐ Resid 8d. Describe h			Specify)		
Divis	- 9	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injubulged	ıry - At hor . (Specify)	me, farm, stre	et, factory,	office		2	8f. Location (S City or Tow		Number o	or Rural	Route Num	ber,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical	29a. Certifier 1 Certifying Phy: (Check only one)	sician: To the best of ner: On the basis of and manner sta	examinati	rledge, death on and/or inv	occurred a estigation,	t the time	e, date and nion, death	place, a	nd due to the o	ause(s) a late and p	and manne place, and	er as sta due to t	ted. the cause(s	)
)	To T com	M	29b. Signature and title of certifier	week				License 098			4		signed (M ch 10			
			30. Name and address of person who co Barry Rosenbaum, 1					Ken	sinat	t on	MD 20	895				
2.	Sta Registr		31. Date filed (Month, Day, Year)  MAR 11 2005	32. Registra	r's Signati	IFA		A.C.II		-011,	110 20	~ / /				

			State of Maryland / Department of Health and Mental Hygiene  Certificate of Death  State of Maryland / Department of Health and Mental Hygiene  Certificate of Death
	Physic /Medi		1. Decedent's Name (First, Middle, Last)  Aaron COHEN  2. Date of Death Month Month 7, 2005  3. Time of Death 12:07 PM
	Examir	ner	4a. Facility Name (If not institution, give street and number)  Laurel Regional Hospital  4b. City, Town, or Location of Death  Laurel  Prince George's  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  If Under 1 Year   If Under 24 Hrs.   8. Date of Birth  9. Birthplace (State or Foreign
	Funeral Director		224-22-1680 X M 2 F 82 Yrs. Months Days Hours Min. (Month, Day, Year) Country) Visual Residence of Decedent
	the Maryla 286-f shov	ector	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 10d. Inside City Limits 1□Yes 2♥No
	ath with 1	rai Dir	10e. Street and Number 1804 Hopefield Road 10f. Zip Code 20905 10g. Citizen of What Country? United States
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturel", or items 23a or 28e-f show many injury or other treumatic event. The Medical Examples must be multilled at ance.	t by Funeral Director	11. Marital Status  1 Never Married 2 X Maried 3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces? 1 X es Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 X es Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 X es Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 X es Decedent of Hispanic Origin? (Specify Yes or No-If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 X es Decedent of Hispanic Origin? (Specify Yes or No-If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 X es Decedent of Hispanic Origin? (Specify Yes or No-If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 X es Decedent of Hispanic Origin? (Specify Yes or No-If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 X es Decedent of Hispanic Origin? (Specify Yes or No-If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 X es Decedent of Hispanic Origin? (Specify Yes or No-If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 X es Decedent of Hispanic Origin? (Specify Yes or No-If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 X es Decedent of Hispanic Origin? (Specify Yes or No-If Yes, Specify Cuban, Mexican, Puerto Rican, etc.)
21215-0036	d within 72 h piene. r than "netu the Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary(Secondary (0-12) College (1-4or 5+)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Deli Manager  Food
Maryland 2	ould be filed Mental Hyg arked othe	To Be C	17. Father's Name (First, Middle, Last)  George Cohen  18. Mother's Name (First, Middle, Maiden Sumame)  Sadie Lefkowitz
	and 2 sh iaith and 127 is m er treum		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  1804 Hopefield Road, Silver Spring, MD 20905
Baltimore,	Pages 1 and of He not: If item		20a. Method of Disposition  1 To Burial 2 Cremation 3 Removal from State  1 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Mt. Lebanon Cemetery 03/10/05  Adelphi MD
Balti	permit. Departn Imports any inju		21. Signature of Fundal Service Lecenses  22. Name and Address of Facility  Torchinsky Hebrew Funeral Home
	Physician		23a. Part Leder the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  20012  Approximate Interval Between Onset and Death  Approximate Interval Between Onset and Death
	/Medical Examiner		Due to for as a consequence of):
	cate be executed physician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  b. ILCUMY CVV 15 // 15 /
68760,	ficate be ex physician is the buria	dicai	d
.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   2   No   9   Unknown   9   Unknown   9   Unknown   9   23c. If yes, outcome of pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnancy   23d. Date of delivery   Month   Day   Year   1   Yes   2   Yes   Ye
rds, P	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown
al Records,		Completed	Dun HS MI In S  24a. Was an autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No 1 □ Yes 2 □ No
Vital	Physicien: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner?  1 Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other: 4 Nursing Home 5 Residence 6 Other (Specify)
Division of	e le	Certification; T	27. M_nner of Death  1 Natural 2 Accident  28a. The of Injury (Month, Day Year) 28b. Time of Injury 28b. Time of Injury 3 Cook M  1 Yes 2 No  28c. Injury at Work? 1 Yes 2 No
Divi	To the Hospitel or Attendit within 24 hours after death. To the Funerel Director; A: completely filled in by the fu	Certifi	Suicide 6 Could not be determined 28e. Place Injury - At home, farm, street, factory, office building, etc. (Specify)  28e. Place Injury - At home, farm, street, factory, office building, etc. (Specify)  Nome  28f. Location (Street and Number or Rural Route Number, City or Town, State) 4822 Hed in Silver
	To the Hospitel or within 24 hours afte To the Funerel Directional Completely filled in the Funerel Direction of the Fune	Medical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
		Σ	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  Alberta Druce  29d. Date signed (Month, Day, Year)
	10+1		30. Name and deress of perion who impleted drugs of death (Item 23a) (Type, Print)  Joseph Layug, M.D. 14201 Laurel Park Dr. Suite III Laurel, MD
•	Sta Registr		31. Date filed (Month, Da), Year)  MAR 1 1 2005  32 hegistrar's Signature

218-20-9685

GHOAM

Ruth Coburn

# State of Maryland / D

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

/ Departm	nent of I	Health a	and M	ental	Hygien
Certific	cate of	Death			Reg No

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Reg. No.	U	U	J		U	2	6	-
gicile	0	0	g-ora	,	-	42		

MD 2,804

9. Birthplace (State or Foreign Country) ORIOLE, MARYLAND

	Dhyaiai	<b>a</b> n	Decedent's Name (First, Middle, L.	ast)					2. Date of I	Death	Vons	3. Time of Death
	Physici /Media		RUTH M. COBURN						Marc	h	1 2005	6:404
	Examir		4a. Facility Name (If not institution, gi	ve street and number)		4	b. City, Town, or	Location of D	eath	40	. County of Death	1
				anov			MA	esst	Inne		SOW	ierset
	Funeral			Sex 7.Ag 1□M 2ᡚF	e (In yrs. las		If Under 1 Year Months Days	Hours N	lin. (Month, I	Birth Day, Year)	9. Birth	place (State or Foreig intry)
ļ.	Director		218-20-9685 Usual Residence of Decedent	X	79	115.			01-18	-1926	ORIO	DLÉ,MARYLA
	/land		10a. State 10b. County		10c. City, 7	Town or Loca	tion					10d. Inside City Limits
	Many I sh	to	MD WICON	1ICO	SALIS	SBURY						1 ☐ Yes 2 📉 No
	r 28g	Director	10e. Street and Number				10f. Zip Code			10g. Cit	tizen of What Cou	intry?
	23e c	aiD	30555 BENNETT ROA	AD				21804			USA	
	after death with the Maryland or Items 23e or 28e-f show criner must be notified at	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		13. Wa	s Decedent of Hi		(Specify Yes or fuerto Rican, etc.)	10-	14. Race - Amer Black, White	ican Indian,
9		by Fu	1 Never Married 2 Married	1 ☐ Yes 2 💢 i	No		Yes 2X No	Specify:			Specify: WH	
2-003p	2 3 3		3  Widowed 4 □ Divorced  15. Decedent's E	Year or Dates:	1 1	163 Deceder	ata Hayal Occupa	otion		1 40) 16		
Ċ	in 72 n "nat	Completed	(Specify only highest gr	ade completed)		(Give kir.	nt's Usual Occupa nd of work done o NOT use retired	ation during most of	working	16b. K	ind of Business/Ir	ndustry
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2	e filec Il Hyg othe vant,	Bec	17. Father's Name (First, Middle, Las	1)					Name (First, Midd	le, Maiden		
/iand	uld by Menta rrkad ritic e	To E	NORWOOD BLOODSWOF	RTH				ATRICE	MCDANIE	L		
a	s 1 and 2 should t Health and Mer Item 27 is marks other traumatic	ľ	19a. Informant's Name/Relationship	(Туре, Print)		19b. Mailing	Address (Street a	and Number or	Rural Route Num	ber, City o	or Town, State, Zi	o Code)
Z	and salth n 27		OLLIE GRAVENOR -	DAUGHTER				STREET	, SNOW H	ILL,	MARYLANI	21863
ore O			20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 [	Removal from State	20b. Plac	e of Dispositi etery, cremat	on (Name of ory or other place	Θ)	Date	20c. Lo	ocation - City or T	own, State
Ē	mit. Pages partment of tortant: If Its injury or o		'4 Donation 5 Other (Speci		SPRIN		MEM.GDN		-17-2005			
Daltimo	permit. Page Department of Important: tf any injury or once.		21. Signature of Funeral Service Lice	nsee //	,				BOUNDS FI			
	ED = 8 0		1/1/43300 /1/	Helly							Y, MARYLA	ND 21804
			23a. Part . Enter the disease, o con shock, or heart failure. List only	one cause op each lir	the death. [ le.				fiac or respiratory	arrest,		Approximate Interval Between Onset and Death
1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	d	STASTA		MECA	NONA				Onset and Death
	Examiner			Due to (or as								
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as		(C V i)						
	d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events									
Š	exec an an rial-tr	Exa	resulting in death) Last	Due to (or as	a consequen	nce of):		-		5		
00/00	death certificate be executed e attending physician and id for use as the burial-transit	clan/Medical		d								
ŏ	ing pl	Med	IF FEMALE:									
א מ	ath ce ttend or us	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth	2 ☐ Fetal de	ath 3 □Ec	topic pregnancy			2	23d. Date of delive Month	*
		ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death	h 5□01	ther (specify)				MORE	Day Year
Ľ	Physician: The law requires that the this certificate has been signed by the ral director, page 2 should be detache	/ Physi	Part II. Other significant conditions	contributing to death bu	ut not resultin	a in the unde	dving cause give	n in Part I	23e. Did	tohacco u	ise contribute to the	ne cause of death?
ה ס	uires Isign Id be	d by					, , , , , , , , , , , , , , , , , , , ,				/	pably 4 □Unknown
3	w req beer shou	ompleted							24a. Wa		24h Wass auto	Coding to the second stable
מ	ding Physician: The lav h. After this certificate has funeral director, page 2	dmo	-						- auto	opsy ormed2	prior to co	psy findings available mpletion of cause of
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>	ysicia s cer direct	o B	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatie	nt 2□ER/	/Outpatient	3□ DOA Othe	~ /	eath <i>(Check only</i> Home 5□ Res		COthor (Second	
5	g Ph ter thi	T:U	27. Manner of Death	28a. Date of Injur (Month, Day	y 28	b. Time of	28c. Injury Work		28d. Describe			Y/
2	auth. or: Afr	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigatio	n	7041)	Injury		r 'es 2□No				
<u> </u>	I or Attendi after death. Director: A	ertification	3 Suicide 6 Could not be determined	28e. Place of Injubuilding, etc	ry - At home . (Specify)	, farm, street,	factory, office		28f. Location City or To	(Street and	d Number or Rura	l Route Number,
2	oital c urs af urat D	O										
	To the Hospital or Attending within 24 hours after death.  To tha Funerat Director: After completely filled in by the fune.	dical	Check only Z Medical Exal	nysician: To the best of miner: On the basis of	examination	dge, death oc and/or invest	curred at the time	e, date and pla inion, death oc	ce, and due to the curred at the time	cause(s) , date and	and manner as si	ated.
	ithin 2 o tha	Med	29b. Signature and title of certifier	and manner sta	ted.		29c. License				e signed (Month,	
												vay, rear
	CB		, N. U	Naher 347094 3/14/05								

State Registrar DHMH 17 Rev 1/2001

MAR 1 4 2005

vel 31. Date filed (Month, Day, Year)

NATESIN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1415

32. Pagistrar's Signature

6. DIVISION

SALISBURY

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician P 03 08 2005 18:42 DONALD LEE COLEMAN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PENINSULA REGIONAL MEDICAL CENTER WICOMICO SALISBURY If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month Day, Year) 07-29-1951 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign **Funeral** 1X M 2 ☐ F CHESTERTOWN, MD. 53 214-82-7059 **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthan "natural", or Items 23a or 28a-f show the Madical Examiner must be nutified at TX☐Yes 2 ☐ No Director MD WICOMICO SALISBURY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 204 BROOKLYN AVENUE 21801 IISA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: þ Specify: 3 Widowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na any mjury or other treumatic event, II a Medie Elementary/Secondary (0-12) College (1-4or 5+) 0 NEVER WORKED NEVER WORKED 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SARAH EMILY BATCHELOR HARRY WRIGHT COLEMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. BOX 1610 , SALISBURY , MARYLAND 21802 CHARLOTTE PITTMAN-CASE WORKER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State MBurial 2 Cremation 3 Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) WESLEY CHAPEL CEM. 03-11-2005 ROCKHALL, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BOUNDS FUNERAL HOME, INC. 705 EAST MAIN STREET, SALISLURY, MARYLAND 21804 23a. Park. Enter the disease, or can plications that caus a me death. Do not enter the mode of dying, such as cardiac or respiratory arrest, swick, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardine /Medical Due to (or as a consequence of): Examiner Asthma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed been s 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒ No has certificate 2)X No 1 🗆 Yes 2 🔯 No or Attending Physiclan: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 ☐ Yes 2X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 💢 DOA this 28c. Injury at Work? Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 X Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D24986 03-10-2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROBERT S. REILLY M.D. 560 RIVERSIDE DRIVE B101 SALISBURY, MARYLAND 21801 31. Date filed (Month, Day, Year) State MAR 14 2005 Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

			For Stete Registrar	State of N	aryland		artment of I		nd Mei	_	jiene	005	10000
			Decedent's Name (First, Middle	, Last)					2.	Date of Dea	th	000	3. Time of Death
	Physicia		Geraldine	I. Clem	ents				,	Month March	Day 9, 200	Year )5	7:25 PM M
-	/Medic Examin		4a. Facility Name (If not institution,				4b. City, Town, o	or Location of		ICLCII		nty of Death	
	LXaiijiii	<u> </u>	1207 Taney Ave	2.			Salisk	ourv			TA7 i	comic	0
	Funeral			6. Sex 7. /	lge (In yrs. la:	st birthday)	If Under 1 Year Months Days		Min. 8.	Date of Birth (Month, Day	1		place (State or Foreign intry)
	Director		227-82-1207	1 □ M 2 🔀 F	52	Yrs.	MOIIIIS Days	Hours		2/9/19	52		rginia
	pu »		Usual Residence of Decedent  10a. State 10b. County		10c City	Town or Lo	eation					т	10d. Inside City Limits
	anyla shov	7											1 ☐ Yes 2 🛣 No
	he M	Director	Maryland Wicon  10e. Street and Number	1100		Salisk	10f. Zip Code				10g. Citizen	of What Cou	intar?
	with 1	급	1207 Taney Ave				i i						211G y :
	eath	era	11. Marital Status	12. Was Deceder	nt Ever in U.S.	13.1	21801 Was Decedent of		in? (Specif	v Yes or No-	US 14. B	A Race - Amer	ican Indian.
10	fter d r Item iner	Funeral	1 Never Married 2 Marri	Armed Force	s?	'	If Yes, specify Cub	an, Mexican,	Puerto Ric	an, etc.)	В	Black, White	, etc.
036	urs a al', o	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates	);		1 ☐ Yes 2 🔯 No	Specify:			Spe	cify:	white
5-0036	72 hours after death with the Maryland natural', or Hems 23e or 28a-f show Jisal Esaniher must be neilliad at	Completed by	15. Decedent (Specify only highes			16a. Dece	dent's Usual Occu kind of work done	pation during most	of working		16b. Kind of	Business/Ir	ndustry
2121	within one.	nple	Elementary/Secondary (0-12)	College (1-4c	r 5+)	life.	DO NOT use retire	d)	or worning		74_4_	- f D-	1
2	ygien ygien t, litt	So	12	4+		Nur	se	1 42 14 4					laware
nd	tal H d oth	Be	17. Father's Name (First, Middle, I Thomas E. Clem							First, Middle,	Maiden Sum	ame)	
yla	12 should be filed within "h and Mental Hygiene. 7 Is marked other than "!	2				401 14 11	411 (21)			Reilly	01	01-1- 7	- 0-4-1
Maryland	12 st h and 7 Is n traun		19a. Informant's Name/Relationsh Mark Clements/b				ng Address (Stree				-		
	1 and Healt em 2 ther		20a. Method of Disposition	TOCHEL	20b. Pla	ce of Dispo	anding Constition (Name of		Date		20c. Locatio		
Ω	nt of I		1 ⊠Burial 2 ☐ Cremation		e Wic	metery, crer	matory or other pla Memoria	(ce)	3/14/	05	Salisk	-	
3altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural; or items 23e or 28a-f show any injury or other traumatic event, the Madical Examinat must be nutilised at once.		* 4 □ Donation 5 □ Other (Sp. 21. Signature of Funeral Service I		Pa	rk	2. Name and Addre			05	Dails	π. у,	
Ba	permit. Departr Importe any inju		Vitl 1	Compre	CESP	H	lolloway	Funera	al Hom	ne Prof	essio	nal As	sociation
			23a, Part1. Enter the disease, or	complications that caus	ed the death.		01 Snow					2180	Approximate
			shock, or heart failure. List Immediate Cause (Final	only one cause on each	line.	1. •	0	1 /					Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Pue to (or	STOT	ance of):	proa	1 (	BM	11			dyrs
	Examiner												
		Jer	Sequentially list conditions, if any, leading to immediate	Due to (or	as a conseque	ence of):							
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c									
0,	an ar irial-t	EX	resulting in death) Last	Due to (or	as a conseque	ence of):							
8760,	death certificate be executed e attending physician and of for use as the burial-transit	dical		d									
9	ing p	Med	IF FEMALE:										
Вох	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?		2 Fetal of	death 3	Ectopic pregnand	у				Date of delive Month	very Day Year
	the a	Physician/Med	1 ☐ Yes 2 ☐ Vo 9 ☐ Unknown	4∟Pregnant 9□ Unknowr	at time of dea	atn 5L	Other (specify) _						
P.0	that tl		Part II. Other significant condition	ns contributing to death	but not result	ting in the u	nderlying cause gi	ven in Part I.		23e. Did to	bacco use c	ontribute to	the cause of death?
Vital Records,	w requires that the death certific. been signed by the attending p. should be detached for use as t	Completed by	-							1 🗆 Y	es 2 🗆 No	3 🗆 Pro	babiy 4 Unknown
COL	w requ	lete								24a. Was a	an 24	b. Were aut	topsy findings available
Re	The law cate has b page 2 sl	ш								autop perfor		prior to death?	topsy findings available ompletion of cause of
a	iician: The certificate rector, pag	e Co	25. Was case referred to medical					26 Place	of Dooth //	1 Yes	2 No	1 🗌 Yes	2 L No
	Physician: this certific ral director,	To Be	examiner?	Hospital: 1 ☐ Inpa	tient 2□E	R/Outpatie	nt 3 DOA Ot	hor	rsing Home	X	ence 6 🗆 (	Other (Spec	ify)
of			27. Manner of Death	28a. Date of I		28b. Time o				d. Describe h			,,
ion	Attending F r death. ector: After by the funera	atio	Natural 5 Pendin 2 Accident investig	9	Jay (Gar)	Injury		Yes 2 \\	No				
Division of	er der recto by th	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ined   286. Place of	Injury - At hon etc. (Specify)	ne, farm, st	reet, factory, office		28f	Location (S City or Tow	treet and Nu	mber or Rui	ral Route Number,
Ō	rs aft rs aft al Di	Cer											
	despi	edical	29a. Certifier Certifyin	g Physician: To the be Examiner: On the basis	st of my know	rledge, deat	h occurred at the t	ime, date and opinion, deat	d place, and	d due to the d	ause(s) and late and plac	manner as	stated. to the cause(s)
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medi	one)	and manner				se number	_		29d. Date sig		
	T W T	-	29b. Signature and title of centrile		1	1	Zac. Licen	~ ~ Z	770	2   °	Jaie sig	2 ).	205
	OB				1	2000	D.i.a	00	1-12	5		, - //	
	1/00		30. Name and address of person	wno completed cause of	death (Item)	23a) (Type,	Print /	732	2	Salis	1	MAD	21807
	Sta	ite.	31. Date filed (Month, Day, Year)	32. Reg	strar's Signati	ure .				CE2/13	X	100	7100
* .	Regist		MAR 1	5 2005	der.	K A	perk						

			For State Registrar	State of Ma	ryland / Depa <i>Ce</i>	artment of I				ene g. No. 20	na	10260
			Decedent's Name (First, Middle, Last)						2. Date of Death		W W	3. Time of Death
ш	Physici		Charlotte	Mae	Dove	<u> </u>			March 7	<sup>Day</sup> 200	Year 5	11:10 a M
	/Medio Examir		4a. Facility Name (If not institution, give s			4b. City, Town,	or Location	of Death		4c. County	of Death	
	LXdiiii		Calvert Memorial H	ospital		Prince	e Fred	deric	k	Ca	lver	t
	Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. last birthday)	If Under 1 Year Months Days	If Under		8. Date of Birth (Month, Day, Oct 26,	Year)	9. Birth	place (State or Foreign
	Director		230–14–5715	M 2X1F	80 Yrs.	WOITINS Days	riodis		Oct 26,	1924	Virg	ińia
	pu ,		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	reation					T.	10d. Inside City Limits
	aryla shov	2			Too. Only, Town of Ec							1 ☐ Yes 2X No
	Ne M	Director	MD Anne Ar	under		Deale			10	g. Citizen of W	that Cour	
	with the Bor S						- 4		10			nury :
	sath	era	5597 Nutwell Sudl	ey Road 2. Was Decedent E	iver in IIS 13	207!		igin? /Sne	cify Yes or No-	US.		can Indian,
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 Ie marked other then "natural", or Items 23e or 28e-f show other traumatic event, the Mydical Examinar must be notified at	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 💆 N If Yes, Give	0	Was Decedent of If Yes, specify Cul 1 ☐ Yes 2X No			Rican, etc.)		k, White,	etc.
21215-0036	hour tural	d b	15. Decedent's Educ	Year or Dates:	163 Dece	dent's Usual Occu	nation		10	6b. Kind of Bu		ite
7	n 72	Completed	(Specify only highest grade	completed)	(Give	kind of work done DO NOT use retire	during mos	t of workir	ng "	ob, Kilid di Bu	3111623/111	loustry
12	filed withi Hygiene. other then ent, the M	E	Elementary/Secondary (0-12)	College (1-4or 5-		nemaker	,			own l	nome	
9	filed Hygir other ent, II		17. Father's Name (First, Middle, Last)		1101	CITICATION	18. Mothe	er's Name	(First, Middle, M.			
Maryland	2 should be filed v n and Mental Hygie le marked other t raumatic event, III	То Ве	Judson		Gordor	1	Sad	lie	Vivia	n i	Jenn:	ings
AL Y	shou nd M mar	-	19a. Informant's Name/Relationship (Typ	e, Print)	19b. Maili	ng Address (Stree	t and Numb	er or Rura	l Route Number,	City or Town,	State, Zip	Code)
	and 2 ealth a n 27 le		Gloria Jean Canter	Haws, da	ugh. 559	7 Nutwell	1 Sudl	ey R	d., Deal	e, MD	207	51
ē,	s 1 and 2 f Health item 27 I	li	20a. Method of Disposition		20b. Place of Dispo	sition (Name of matory or other pla	ace)	D	ate 2	0c. Location -	City or To	own, State
Ę	Pages nent of int: If it		1 X Burial 2 ☐ Cremation 3 ☐ Re  `4 ☐ Donation 5 ☐ Other (Specify)	moval from State	Resurrect			03–1	1-05	Clinto	n, M	D
Baltimore,	그 문 변 등		21. Signature of Funeral Service License		Colored to the second s	2. Name and Addr					-	
ä	Depa Impo eny ir		Willeam	R- GA	ا مدد	Rausch F	uneral	L Hom	e, P.A.,	Owin	gs,	MD 20736
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	ations that caused	the death. Do not en	er the mode of dy	ing, such as	cardiac o	r respiratory arres	st,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	G	Respirati	~~	5-1	1100				Onset and Death
4	/Medical		resulting in death)	Due to (or as a	consequence of):	sm .	1000	THIC				
	Examiner		Sequentially list conditions b	C	OPD						3	Several
_	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disease or injury	Due to (or as a	consequence of):							monthy.
	nd nd transi	Examine	that initiated events									
ó,	e exerian a	ĕ	resulting in death) Last	Due to (or as a	consequence of):							
8760	cate be executed physician and the burial-transit	dlcal	d									
Θ	artific ing p	Mec	IF FEMALE:									
P.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and cage 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 ☒ No 9 □ Unknown	ic. If yes, outcome of 1 Live birth 2 4 Pregnant at 1 9 Unknown	2 ☐ Fetal death 3 ☐	Ectopic pregnand Other (specify)	Э			23d. Date Mor		ery Day Year
	res that igned by be deta		Part II. Other significant conditions con	ributing to death bu	it not resulting in the u	nderlying cause g	iven in Part I	l.	23e. Did toba	acco use contr	ibute to t	he cause of death?
of Vital Records,	quires n sign	d by	Correran d	nease	- Hype	from			1 ☐ Yes	2 □ No	3 🗌 Prob	pably 4 Unknown
S	w require been sign should t	Completed	Diables (	nelles	0.				24a. Was an	24b. V	Vere auto	ppsy findings available impletion of cause of
Re	he lav e has age 2 (	щc							autopsy perform 1 Yes 2	ed? d	leath?	
ā	icien: Th certificate rector, pag	Ö	25. Was case referred to medical				26 Place	a of Death	(Check only one		☐ Yes	2 No
5	Physicien: this certificatal director,	To B	examiner?	spital: 1 Inpatier	nt 2 ER/Outpatier	nt 3 DOA	her		ne 5 Residen		er (Specif	(v)
	g Phye er this eral di		27. Manner of Death	28a. Date of Injur	y 28b. Time o				28d. Describe how			,,
o	nding Ith. :: Afte	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Day	Year) Injury		ork? ]Yes 2. [	No				
Division	l or Attending I after death. Director: After I in by the funer	ifica	3 Suicide 6 Could not be determined	28e. Place of Inju	ry - At home, farm, st	reet, factory, office	)	2	28f. Location (Stre City or Town,	et and Numbe	er or Rura	al Route Number,
	s afte	Certification;	4 - Homolog	, ballaling, oto	. (Opachy)				ony or rown,	J.L.C.		
	To the Hospital or Attending Physicien: The within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	29a. Certifier 1 Certifying Phys (Check only one)	ician: To the best of er: On the basis of and manner state	of my knowledge, deat examination and/or in ted.	h occurred at the tweetigation, in my	time, date ar opinion, dea	nd place, a ath occurre	and due to the cau ed at the time, dat	use(s) and mai se and place, a	nner as s ind due to	tated. the cause(s)
	Fo th within Fo th	Me	29b. Signature and title of certifier			-	ise number		29	d. Date signed	(Month.	Day, Year)
			> Thum	Aonson	7	D	00271	189		3/7	105	_
			30. Name and address of person who	mpleted cause of de			,				. k	
_	4		1000		2417 Solo	non's Is	land	Ro	ad, Itu	ntingto	wn	MD, 20639
	Sta		31. Date filed (Month, Day, Year)	32. Registra	r's Signature				•	5		,
la.	Regist	rar	MAR 0 8 2005	Bus 1	Sperte							

DHMH 17 Rev 1/200

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene
Amend Items 23a,25,27,28a-f per ME, G844,06/10/05dhb

Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Year Month **Physician** Evelyn Mae Dawson MARCH 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner NoRTH ARUNDER
5. Social Security Number 6. Sex BURNIE ARUNDEL HOSTITAL ANNE GLEN Il Under 24 Hrs. 8. Date of Birth (Month, Day, Aug. 5, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Months Davs 1 □ M 2 🖾 F Kansas 515-16-0561 1928 76 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State or 28a-f ahow other traumatic event, the Medical Examiner roust be notified at 1 AYes 2 No Director Md. Anne Arundel Severn 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 1353 Dicus Mill Road 21144 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Items 11. Marital Status Black, White, etc. 1 Never Married 2 Married ŏ Specify: White 1 ☐ Yes 2X No Specify: ð Maryland 21215-003 3 Widowed 4 □ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Health and Mental Hygiene. tem 27 Is marked other than College (1-4or 5+) Elementary/Secondary (0-12) US Gov't Supervisor 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Julian Oscar Peterson Emily Erickson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 879 Mt. Airy Road, <u>Davidsonville</u>, <u>Maryland 21035</u> Thomas E. Dawson - son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ite any injury or ot 03-12-05 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Alexandria, VA. Metropolitan Crematory 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Sepvice Licensee DOC . • 6512 N.W. Crain Hwy., Bowie, Maryland 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) G-An GREWOUD **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) CERTIFICATION APPROVED BY MEDICAL EXAMINER Examine burial-transit Due to (or as a consequence of) Box 68760. attending physician for use as the buria certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) hed by the a P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? sign. Records, Completed by 4 Unknown 3 Probably 1 Yes 2 No Hip fracture, Hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 1 Yes 2 No 1 Yes 2 No certificate of Vital To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 25 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred the funeral 28b. Time of 27. Manger of Death Certification: After Injury Division 5 Pending varural 1 ☐ Yes 2**X** No 02/24/2005 s after death. **Unknown**<sup>M</sup> investigation Subject fell 2 XAccident 6 Could not be 281. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide 1353 Dicus Mill Rd., Severn, MD At home within 24 hours a

To the Funeral I

completely filled 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 20055703 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tsion Berhane MD, 301 Hospital Drive, Glen Burnie, Maryland 21061 31. Date filed (Month, Day, Year) 2. Registrar's Signature State MAR 1 1 2005 Registrar

DHMH 17 Rev 1/2001

Every

AWSON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** Dav Gertrude P. Diggs 2005 March /Medical 4:00 а 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mariner of North Arundel 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 25 F 92 Director 219-30-4022
Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28a-f show Examiner must be notified at 17∏Xes 2 □ No Directo Maryland Anne Arundel Crownsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 'natural', or Items 23a 1260 Sunrise Beach Road 21032 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black ۵ 3℃Vidowed 4 □ Divorced Be Completed injury or other traumatic event, the Madical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry le marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12th Private Family permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 te marked other any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Hall Sisie Parker 19a. Informant's Name/Relationship (Type, Print)
Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Mabel E. Diggs law</u> 791 Queenstown Rd. Severn, Maryland 21144 20b. Place of Disposition (Name of cometery, crematory or other place)
Maryland Veteran 20a. Method of Disposition 20c. Location - City or Town, State XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cemetery
Name and Address of Facility 3/11/05 Crownsville, Md. 21. Signature of Funeral Service Licensee Reese & Sons MOrtuary, west St. Annapolis, Md. Larry J. Reese MOU 183 23a. Part1. Enter the risease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause oppach line. Approximate Interval Between Anset and Death Cere brovas cular Aceide Immediate Cause (Final Physician Weeks disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or 🍑 Examiner The law requires that the death certificate be executed Due to (or as a consequence of): use as the burial-Division of Vital Records, P.O. Box 68760, the attending physician by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 1 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 🔼 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 1 Nucering Home 5 Residence 6 Other (Specify) ٩ 1 Yes 2 10 1 | Inpatient 2 | ER/Outpatient 3 | DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Injury at Work? After 1 Natoral 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 1 🗓 🚅 tifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Doctor trending ss of person who completed cause of death (Ite (Item 232) (Type, Print) I RITCHIE UWT PASADENA MD & 1122 2. Registrar's Signature State Registrar

			1 - For State Registrar	State of M	laryland / D	epartmen <i>Certificat</i>				ene 005	10266
			1. Decedent's Name (First, Middle, La	ist)					2. Date of Death	1	3. Time of Death
	Physici		Mary C. D	ulany					Month March 1	Day Year	220pm M
	/Medio Examir		4a. Facility Name (If not institution, gir		)	4b. City,	Town, or Loc	cation of Death	March	4c. County of Death	1-0.
			20740 Crystal	Hill Circ	le	Ger	manto	<b>v</b> n		Montgome	erv
	Funeral		5. Social Security Number 6.	Sex 7. A	ge (In yrs. last birti	hday) If Under Months		Under 24 Hrs.	8. Date of Birth	O Dist	place (State or Foreign
	Director		214-60-5894	1 □ M 2 🛣 F	52	rs.	Days	iours wiiri.	May 2, 1	.952 Wash	ntry) ington D.C.
	pur *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	and anotion					
	anyla shov	-	Maryland Montgo	me <b>r</b> v	German						10d. Inside City Limits 1 ☐ Yes 2 No
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	with t	ā	10e. Street and Number			10f. Zip			10	g. Citizen of What Cou	ntry?
	s 23	rai	20740 Crystal H				20874	1.011.00		U.S.A.	
	within 72 hours after death with the Maryland ene. then "natural", or Items 23e or 28e-1 show te Madical Exer, ther mast ke multified at	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Decedent Armed Forces 1 Yes 2 D	?	If Yes, spec	dent of Hispa cify Cuban, N	nic Origin? (Sp flexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,	can Indian, etc.
36	rs af	by F	3 ☐ Widowed 4 ☑ Divorced	If Yes, Give		1 ☐ Yes	2∭XNo S	pecify:		Specify: Lib	ite
21215-0036	2 hou	ed	15. Decedent's E	ducation	16a.	Decedent's Usua	al Occupation	1	1	6b. Kind of Business/Ir	
15	n n	Completed	(Specify only highest gr Elementary/Secondary (0-12)	ade completed)		(Give kind of wo life. DO NOT us	rk done durin	ig most of work	ng	J. S. Gover	
212	d with	Eo	12th	College (1-4or		mputer	- Webb	Suppor		F.D.A.	
	e filec I Hyg othe	Be C	17. Father's Name (First, Middle, Las	')					(First, Middle, M		
<u>a</u>	uld be denta rkad rtc ev	To B	Paul Ellwood Be	rkeley			M	largaret	Phyllis	Ho1z	
Maryland	12 should be filed within hand Mental Hygiene. 7 is marked other then "freumatic event, tre M		19a. Informant's Name/Relationship	Type, Print)	19b.	Mailing Address	(Street and	Number or Run	I Route Number,	City or Town, State, Zip	Code) 20874
	alth a		Rilee C. Dulany	<ul> <li>Daughter</li> </ul>	20	740 Cry	stal H	lill Cir	cle, Ger	mantown, M	aryland
ē,	of Herm Item		20a. Method of Disposition			Disposition (Nari	ne of	1	Date 2	0c. Location - City or To	own, State
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s or 28s-1 show any injury or other traumatic event, It is Marical Exact intermist be prelified at anote.		1 Burial 2 Cremation 3 C 4 Donation 5 Other (Speci		,	uls Cem		3/16/	05 Ge	rmantown,	Marvland
alti	mit. Sartm Sorta / inju		21. Signature of Funeral Service Lice	NS00	)		-			neral Home	2
m	Depar Impor any ir		Hovert L.	Willian	ns	011n L	. Mole	sworth	P.A., Fu	neral Home	20072
			23a. Part1. Enter the disease, or con	plications that cause	d the death. Do n	ot enter the mod	klage le of dying, si	ich as cardiac (	or respiratory arres	s, Maryland	20872 Approximate
	Physician		shock, or heart failure. List only Immediate Cause (Final	,							Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. CHEUN	a consequence o	DNCHIT	12				(EAP)
	Examiner			CITROL			41 1	7	isease		1
		e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	U	a consequence o			370 G D	126074		POR 4 3
	uted d ansit	Examiner	Cause (Disease or injury that initiated events	0							
ó	exec an an rial-tr	Exa	resulting in death) Last	Due to (or as	a consequence o	f):					
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	tifica ng ph as th	ledi									
Вох	h cer endir	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy 2 Fetal death	2 DEstanta				23d. Date of delive	эгу
	deat	icia	in the past 12 months? 1 ☐ Yes 2X No	4 Pregnant a		3 ☐Ectopic pro				Month	Day Year
P.0	by the	hys	9 Unknown	9Ll Unknown							
	res that the de igned by the a be detached f		Part II. Other significant conditions	contributing to death I	out not resulting in	the underlying ca	ause given in	Part I.	23e. Did toba	cco use contribute to the	ne cause of death?
rd	w require been sign	ed	HISTORY Of M	ITTAL STE	112011				1. <b>∑</b> ≪¥es	2 ☐ No 3 ☐ Prob	ably 4 Unknown
Records,	aw re ts bea	Completed by	Hysothyzois	15 m					24a. Was an	24b. Were auto	psy findings available
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Vital	an: rtifica tor, p	0	25. Was case referred to medical				26.	Place of Death	1   Yes 2   (Check only one)	No 1 ☐ Yes	2 No
>	yslci is cer direc	To B	examiner? 1 Yes 2 Wo	Hospital: 1 ☐ Inpati	ent 2 ER/Out	patient 3 DO	0.1			ce 6 ☐Other (Specifi	v)
Jo C	g Ph		27. Manner of Death	28a. Date of Inju	Jry 28b. Ti	me of 2	8c. Injury at		28d. Describe how		<u>'/</u>
Ö	ath. r: Aft	atio	1 XNatural 5 ☐ Pending 2 ☐ Accident investigatio		19 1041)	Jury M	Work? 1 ☐ Yes	2 No			
Division	Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	289. Place of in	jury - At home, fari	m, street, factory	, office		28f. Location (Stre	et and Number or Rura	I Route Number,
Ö	s after s afte	Sert	4 CHOMICOB	ballaing, e	tc. (Specify)				City or Town,	State)	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funaral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier 1X Certifying Pl	nysician: To the best	of my knowledge,	death occurred	at the time, d	ate and place, a	and due to the cau	se(s) and manner as si	ated.
	he H in 24 he Fi	Medical	(Check only 2 Medical Examone)	niner: On the basis of and manner st	of examination and	or investigation,	in my opinio	n, death occurre	ed at the time, dat	e and place, and due to	the cause(s)
	Vith To t	Σ	29b. Signature and title of certifier	P. 11			. License nur		290	d. Date signed (Month,	Day, Year)
)			> Poseph A	DAIIND	•		23.	31-1	M	ADCh 12	2005
	19		30. Name and address of person who	completed cause of	death (Item 23a) (T	Type, Print)			11		
_			JOSEPH ABALL	16220 fra	derick 1	ROAD SU	te 2	13 6A1	thersbur	g MD 228	77
	Sta		31. Date filed (Month Par Year) 4	2005 32. Pagist	rar's Signature	Annell	P		-		
	Registr	ar		1	A STATE OF S	AL THE STATE OF TH	ar.				

			1- For State of Maryland / Department of Health and Certificate of Death	Re	g. No. 2005	10267
۱	Physici		Decedent's Name (First, Middle, Last)  ELMER LINCOLN DUFFEY	2. Date of Death	890 X	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  Mostles  1. Page   Name   Nam	8. Date of Birth	4c. County of Dea	thplace (State or Foreign
	Director		214-03-9867 IMM 2 F 91 Yrs. Months Days Hours Min.	AUG. 8,1	913 MA	RYLAND
	s Maryland ie-f show iified at	ctor	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1
	with the	I Director	10e. Street and Number 10f. Zip Code #1 BALTIMORE STREET, APT 606 21502	10	og. Citizen of What Co U.S.A.	ountry?
980	d within 72 hours after death with the Maryland Jiene. r than "neturel", or items 23e or 28e-1 show the Mackeal Examiner must be notified at	by Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Specify:  1 Yes 2 No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whit	
Maryland 21215-0036	I within jiene. r than "	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  The property of the control	rking	6b. Kind of Business.	
and	d be ental ced c	o Be C	17. Father's Name (First, Middle, Last)  18. Mother's Nam  That II Differed  18. Mother's Nam  That II	me <i>(First, Middle, M</i> IRBY	faiden Sumame)	
Mary	12 should h and Men 7 is marke raumatic		19a. Informant's Name/Relationship (Type, Print)  ANNA DUFFEY / WIFE  #1 PAT.TIMORE ST. AD			
Baltimore, I	f Heal item 2 other		ANNA DUFFEY / WIFE #1 BALTIMORE ST. AP  20a. Method of Disposition 1	Date 2	MBERLAND A 20c. Location - City or CUMBERLAN	Town, State
Balti	permit. Page Department of Importent: If any injury or		21. Signature of Funeral Syrvic, Lio-ns.*  22. Name and Address of Facility  UPCHURCH FUNERAL  202 GREENE STREE	T. CIMBER	LAND. MD	21502
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardian shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):			Approximate Interval Batween Onset and Death
8760,	death certificate be executed e ettending physician and d for use as the burial-transit	Ilcai Examiner	Sequentially list conditions, if any, reading to immediate cause. Enter Inderlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.			YEARS
O. Box 6	that the death certifica led by the ettending pr detached for use as th	Physician/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ □ Unknown		23d. Date of del Month	ivery Day Year
۵	law requires that the as been signed by th 2 should be detache	by	Part ii. Other significant conditions contributing to death out resulting in the underlying cause given in Part i.	23e. Did toba	acco use contribute lo	
Vital Records,	The ate h	Completed			prior to death?  No 1 Yes	utopsy findings available completion of cause of 2 No
	Physiclen: The this certificate ral director, pag	o Be	examiner? Hospital:	ath <i>(Check only one</i> Home 5 ☐ Resider	nce 6 □Other <i>(Spe</i>	cify)
ion of	ding h. After fune	ation; T	27. Manner of Death    Natural   5   Pending   28a. Date of Injury (Month, Day Year)   28b. Time of Injury at Work?   2   Accident   28c. Injury at Work?   1   Yes 2   No	28d. Describe how	w injury occurred	
Division	tal or Atten s after deat al Director: ed in by the	Certification;	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Str. City or Town,	eet and Number or Ru State)	ural Route Number,
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	edical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date oc	e, and due to the cau urred at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
)		M	29b. Signature and title of certifier  29c. License number		d. Date signed (Mont.	
	5 NA		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	^		2603
	Sta Registi		31. Date filed (Month, Day, Year)  MAR 1 1 2005  Server J April	LUMPERI	and mil	aroud

			1 - For State Registrar		Marylai	-	artmen rtificate			l Mental Hy	gien Reg. N	Z II II 5		02	268	}
	Physici	an	1. Decedent's Name (First, Middle, Las	t)						2. Date of De Month	ath Da	ay Year		3. Time o	of Death	
	/Medic		Anthony			e Taran	ito			March	7		5	2005	P 1	Л
	Examir	ıer	4a. Facility Name (If not institution, give		ber)		4b. City,	Town, or	Location of De	ath	40	c. County of De	ath			
			Memorial Hosp						erland			Alleg				_
	Funeral Director		5. Social Security Number 6. Security Number 147-10-1760	9x 7 M 2□F	. Age (In yrs. 86	. last birthday) Yrs.	If Under Months	1 Year Days	Hours Mi		y Year 191	9. B 9 Ne		erse		n
	land w		10a. State 10b. County		10c. C	ity, Town or Lo	cation						10d.	Inside C	City Limits	S
	Hary Fish	ō	MD Allega	any		Cum	nberla	nd							2   N	
	r 28a	Funeral Director	10e. Street and Number				10f. Zip	Code			10g. Ci	itizen of What C	Country?	?		-
	3a o	0	1826 Fre	derick S	treet				21502			USA	,			
	ms 2	Jer	11. Marital Status	12. Was Deced	ent Ever in L	J.S. 13.	Was Deced	ent of H	ispanic Origin?	(Specify Yes or No arto Rican, etc.)	- 1	14. Race - Arr	nerican I	Indian,		_
စ္	within 72 hours after death with the Maryland ane. than "naturat", or items 23a or 28a-f show I.a Mwaligai Examii at maat kw moliified at	Fu	1 ☐ Never Married 2 💢 Married	Armed Ford	No		nt Yes, spec 1 ☐ Yes 2		n, Mexican, Pue Specify:	erto Rican, etc.)		Black, Wh				
5-0036	urat',	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dat	es:	111	1 1 1 1 9 2	LAINO	зреспу.			Specify: V	Vhit	е		
Š	72 h	Completed	15. Decedent's Ed (Specify only highest grad	ucation de <i>completed)</i>		16a. Dece	dent's Usua kind of wor	l Occupa	ation during most of w	rorking	16b. k	(ind of Busines	s/Indust	ry		
2	vithln ne.	m m	Elementary/Secondary (0-12)	College (1-4	for 5+)				)					_		
2	led y lygie her t	ပိ	12 17. Father's Name (First, Middle, Last)			Suj	pervis	sor	40.14.11.1.11	(F)		Manufac	tur	ing		
anc	be fi	Be	_		Da	Tarant				ame (First, Middle,	Maider	,				
<u> </u>	i Mer Marke Parke	ို	James		De				Clara			Cozzo				
Maryland 2121	12 sh h and 7 is n traun		19a. Informant's Name/Relationship (7 Rita C. De Tarant							et, Cumbe				<sub>de)</sub> 502		
e)	1 and Heelth		20a. Method of Disposition	O / WII.		Place of Dispo				Date						_
altimore,	in it of the control		1 ☐ Burial 2 ☐ Cremation 3 ☐		ate	cemetery, crer	natory or ot	her plac				ocation - City o				
Ħ	tmer tant		`4 ☐Donation 5 ☐ Other (Specify		C							mberlan	,		-,-,-,	
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Heelih and Mental Hygiene. Important: if item 27 is marked other than "naturat", or items 23a or 28a-f show amy injury or other traumatic event, it is Medical Examinating the notified all once.		21. Signature of Furleral Service Licen:	ada	me	22 ح				Adams Fam eet, Cumb				ome, 1502		L e
	Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Conge	on line.	Heart			g, such as cardi	ac or respiratory ar	rest,		On	proximat erval Bet iset and I eks	tween	
	Examiner		Sequentially list conditions, if any, leading to immediate	b. Chron		struct	ive Pu	11mo	nary Di	sease			ye.	ars		
	ate be executed hystoien and the burial-transit	Examiner	cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	c	as a consec										· .	
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	that	y P	Part II. Other significant conditions co	ntributing to dea	th but not res	sulting in the ur	nderlying ca	use give	n in Part I.	23e. Did to	bacco	use contribute t	to the ca	ause of d	leath?	
ds	luires n sign ild be	d by	Ischemic	Heart Di	sease	, Dia	betes	6		1 🗆 Y	es 2	□No 3□P	robably	4 💢	Jnknown	
<u></u>	w require been sli should b	Completed								24a. Was :	20	24h Wara a		God and		_
ě	has ge 2	m d								autop	sy	24b. Were a prior to death?	comple	ation of ca	available ause of	
<u>a</u>			25.14							1 Tes	2 ANo			No		
=	sicien: The law s certificate has l lirector, page 2 s	Be	25. Was case referred to medical examiner? 1 ⚠ Yes 2 □ No	Hospital:	V	_		Othe	_	eath (Check only or						_
ō	Phys this ral dii	۲: ا	1 △ Yes 2 No  27. Manner of Death	1 🗆 Ing		ER/Outpatien		4	4   Nursing	Home 5 Resid			ecify)			
5	ding f h. After funer	io	1 XNatural 5 ☐ Pending	28a. Date of (Month,	Day Year)	Injury	M	Work		28d. Describe h	ow injui	y occurred				
<u>S</u>	ten leat tor: the	icat	2 Accident investigation 3 Suicide 6 Could not be	290 Place o	f Injuny - At h	lomo form etc			res 2□No	206 Legation /C	troot or	d Alumba a a a			. t	_
Division of Vital Records,	itel or Attend is efter death rel Director: /	Certification:	4  Homicide determined	building	, etc. (Special	nome, farm, stre	eet, factory,	Office		28f. Location (S City or Tow			urai Ho	ute Numi	iber,	
	To the Hospitel or At within 24 hours effer of To the Funerel Direct completely filled in by	edical	29a. Certifier (Check only one)  1 ☐ Certifying Phy one)  1 ☐ Certifying Phy one)	sician: To the biner: On the bas and manne	is of examina	owledge, death ation and/or inv	occurred a restigation,	t the tim in my op	e, date and place sinion, death occ	e, and due to the curred at the time, o	ause(s) late and	and manner a d place, and du	s stated e to the	cause(s	)	
	To t To tl	ž	29b. Signature and title of certifier				29c.	License	number	2	29d. Dai	te signed (Mon	th, Day,	Year)		
1	INA			/1-				D	09157		M	arch 7,	200	05		
	,		30. Name and address of person who c	ompleted cause	of death (Iter	m 23a) (Type,	Print)									_
-	ns		Paul Snow	, M.D.,	124	West Th	nird S	Stre	et, Cum	berland,	MD	21502				
	Sta		31. Date filed (Month, Day, Year)  MAR 0 9 2005	32. Reg	jistrar's Signa	ature	110			_						_
	Reaistr	10	1917 G H STANS	E SHOT MA	1 630	Marie Lander Con	Section 1									

	•	For State Registrar	State of	Marylar		artmer <i>rtificat</i>			and M	lental Hyg	giene Reg. No.	2005	1026
Physicia /Medic		Decedent's Name (First, Middle, La.  Barry Va	nce Dic			_				2. Date of Dea Month March	IO Day	Year <b>200</b> 5	
Examin Funeral	er	4a. Facility Name (If not institution, given 12535 Fleetway D. Social Security Number 6. S.	r.		. last birthday)	Oce If Unde	ean (	If Under 2	24 Hrs.	8. Date of Birti (Month, Day	W	orceste  9. Birt	hplace (State or Fore
Director		Usual Residence of Decedent	<b>X</b> M 2□F	59	Yrs.	Months	Days	Hours	Min.	Dec.3,	, Year) 1945	MI	)
th the Maryla or 28e-f shov	Director	10a. State 10b. County  MD Worces  10e. Street and Number	ster		ity, Town or Lo	City	o Code		-		10g. Citiz	en of What Co	10d. Inside City Lim  1X Yes 2  untry?
J within 72 hours after death with the Maryland jiene. Jiene. The "natural", or Items 23s or 28s-f show the Madical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 ⋈ Married 3 □ Widowed 4 □ Divorced  15. Decedent's Ec	12. Was Deced Armed Ford 1 Tes If Yes, Give Year or Da	ces? 2 <b>XN</b> o		Was Dece If Yes, spe 1  Yes	2 No	Specify:	gin? (Spe , Puerto I	ocify Yes or No- Rican, etc.)		4. Race - Ame Black, White Specify: Whi	te
s within liene. r than	Completed	(Specify only highest gra  Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Last)	College (1-5+	4or 5+)	(Give	kind of wa DO NOT u ounta	ork doné d ise retired;	uring most		(First, Middle,	Buil	ding C	ontractor
od ta b e	To Be	George Karl Dic  19a. Informant's Name/Relationship (	kel		19b. Mailir	ng Address	s (Street a	Ann	e Va				ip Code)
1 and 2 Health a mm 27 is thar tra	3	Carol Lynn Dickel  20a. Method of Disposition  1 □ Burial 2 ☑ Cremation 3 □	Bemoval from S			35 Fl	eetwa	ay Dr	٠., (	Ocean (	City,		342
permit. Pages Department of I Important: If its any injury or o		*4 Donation 5 Other (Specification)  21. Signature of Funeral Dervisor Licer	y)	Ca		. Name ar	nd Addres	s of Facility	Th	-05 e Burb din, Mo	age		
death certificate be executed  Wedical  e attending physician and of or use as the burial-transit	dlcal Examiner	shock, or beart failure. List-only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с.	r as a consec r as a consec r as a consec	quence of):	,	C(~	ier					Interval Between Onset and Death
death certifi e attending d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		th 2 ☐ Feta nt at time of o	al death 3	Ectopic pi Other (sp					23	3d. Date of delive Month	very Day Year
es the de de de de de de de de de de de de de	by	Part II. Other significant conditions of	ontributing to dea	ath but not res	sulting in the u	nderlying o	ause give	n in Part I.		23e. Did to			the cause of death?
The taw ate has b page 2 sl	Completed								_	24a. Was a autops perform	sy	24b. Were aut prior to co death? 1 \sum Yes	opsy findings availab empletion of cause o
Physicien: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	Hospital: ,,				Othe			(Check only or			
ding After fune	<b>-</b>	1	28a. Date of (Month)		28b. Time of Injury		28c. Injury Work	4 U Nur	2	ne 5 Reside 8d. Describe he			fy)
To the Hospital or Attandi within 24 hours after death. To tha Funeral Diractor: A completely filled in by the fo	Il Certification:	3 Suicide 6 Could not be determined	building	g, etc. (Speci				dot		City or Town	n, State)		al Route Number,
To the Hos within 24 ho To the Fun completely	Medical	29a. Certifier (Check only one)  29b. Signature and title of certifier	ysicien: To the bas and manne	sis of examina	ation and/or inv	vestigation	at the time, in my op	inion, death	h occurre	d at the time, d	ate and p	nd manner as place, and due signed (Month,	to the cause(s)
i				ARI	C/C/	1 1 2	H11	Un	18	3	3//	2/1 +	

				State of Marylar	nd / Depa		lealth and I	Mental Hygi	•	10270
	Physici /Medic Examin	al	Decedent's Name (First, Middle, Last)     LAURA HARRISON DAY     ArFacility Name (If not institution, give s		0 1	4b. City, Town, o	or Location of Deatl	2. Date of Death Month	14 2005	3. Time of Death
	Funeral Director		5. Social Security Number	MAI MEDICAL (7. Age (In yrs. 84	enfu last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 195–19–192	(ear) 9. Birth Cou	place (State or Foreign intry) YLAND
	in 72 hours after death with the Maryland "natural", or litems 23e or 28e-f show ladical Examinan must be notified at	Director	Usual Residence of Decedent  10a. State  10b. County  MD  WICOMIC  10e. Street and Number		ty, Town or Lo			100	g. Citizen of What Cou	10d. Inside City Limits 1X Yes 2 □ No
	death with ms 23e or	Funeral DI	1014 BEAGLIN PARK	12. Was Decedent Ever in U	J.S. 13.	2	1804 dispanic Origin? (S an, Mexican, Puert		USA 14. Race - Ameri	can Indian,
0036	hours after tural', or Ite	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Amed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		1□Yes 2፟ÑNo	Specify:		Specify: WH	ITE
9500-61212	with iene. iene.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 11		(Give	dent's Usual Occup kind of work done DO NOT use retire HOMEMAK	during most of wor d)	king 10	6b. Kind of Business/Ir	•
ryland	d 2 should be filed in and Mental Hygis T Is marked othar treumatic evant, It	To Be (	17. Father's Name (First, Middle, Last)  IRA BRISTER HARRIS  19a. Informant's Name/Relationship (Type)		10h Maile	na Address (Ctrost	ELSIE M	BROMWEL1	L	- Code)
re, Mary	d 2 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4		MICHAEL DAY - SPOU  20a. Method of Disposition	SE 20b. F	119 F		ELLA STRI	EET, SALISI	City or Town, State, Zi BURY , MARYLA Dc. Location - City or T	AND 21801
Baltimore,	permit. Pages 1 an Department of Heal Importent: If Itam 2 any injury or othar once.		1 Burial 2 Cremation 3 Re '4 Donation 5 Other (Specify)  21. Signature of Superal Service License	CRI	EMATORY 22	OF DELM  2. Name and Addre	ARVA 03-	JNDS FUNE	ELMAR, DELA	ENC.
	Pnysician		23a. Paryl. Enter the disease, a complice shock, or heart failure. Ust only on Immediate Cause (Final disease or condition	cations that caused the deat e cause on each line.	th. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory arres	URY, MARYLAI	Approximate Interval Between Onset and Death
	/Medical Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Wijury	Due to (or as a consequence).	quence of):					
,/60,	ate be executed sysician and he burial-transit	Ical Examiner	Cause (Disease of Mury that initiated events resulting in death) Last	Due to (or as a conseq	quence of):					
O. Box 68	the death certificate be ex y the attending physician ached for use as the buria	hysiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	aldeath 3□	Ectopic pregnanc	′		23d. Date of deliv Month	ery Day Year
rds, P	The law requires that the death tte has been signed by the atter page 2 should be detached for u	by P	Part II. Other significant conditions conf	_	sulting in the u	nderlying cause gr	en in Part I.	23e. Did toba 1 ☑ Yes	cco use contribute to t	the cause of death?
al Kecords,	(4)	Completed		FIBRIL	· 97.3			24a. Was an autopsy performe 1  Yes 2	prior to co	opsy findings available impletion of cause of
ion of Vital	ng Phys ter this neral dii	atlon; To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manne of Death  1 Natural 5 Pending 2 Accident investigation	ospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of Injury	f 28c. Injui Wor	er: 4 □ Nursing H	th (Check only one) ome 5 Residen 28d. Describe how	ce 6 □Other (Specia	59)
DIVISION	ital or Attendir urs after death. ral Diractor: Al lled in by the fu	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Specif	fy)			City or Town,	·	
	To the Hospital or At within 24 hours after or To the Funaral Dirac completely filled in by	Medical	29a. Certifier   Certifying Phys (Check only one)   2   Medicel Exemin	sician: To the best of my knoter: On the basis of examination and manner stated.	owledge, death ation and/or in	h occurred at the tic vestigation, in my o	pinion, death occu	rred at the time, date	se(s) and manner as se and place, and due to d. Date signed (Month,	o the cause(s)
)	, <b>(03)</b>			molated cause of death (Item	m 23a) (Tuna	D2	9168		3/14/05	
	Sta	ito	31. Date filed (Month, Day, Year)  MAR 1 5 200				ST. 5	ALISBUR	(MD)	1804
*	Registr		MAR 1 5 201	05	KA	and i				

DHMH 17 Rev 1/2001

LAMILE DAY 577-24-9986

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UU5 1 - For State Registra Certificate of Death 2. Date of Death 1 Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 2335PM 2005 March /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner SAINT Agnes 1-5. Social Security Number 6. Sex SACTIMOVE Healthcare If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth Month, Day, You NOV. 25 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 KF Country) Months 090-01-3772 Director Usual Residence of Decedent the Maryland 10a. State 10b, County 10c. City, Town or Location 10d. Inside City Limits show other traumatic event, the Medical Examinar must be rigitled at 1 Yes 2 □ No Director OWCUS vag 28a-1 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9 8806 163 Items 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. nnt: If item 27 is marked other than "natural", or Iter 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: 3 Widowed 4 □ Divorced lac 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) tousew) f Home 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be nelius Jordan Nanita ဂ္ 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tywanna Gillespic permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any injury or other trau Doughter & Color Street, Savage, MD 20763

20b. Place of Disposition (Name of cemetery, crematory or other place)

20c. Location - City or Town, State 20c. Location - City or Town, State 20a. Method of Disposition ■Burial 2 □ Cremation 3 □ Removal from State 10/2005 Sultland, MD Lincoln Memorial Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Greene Funeral Home, INC. 21. Signature of Funeral Service Licensee 814 Franklin Street, Alexandria, VA 22314 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician ATMP/ASE)EIDTIE Cardia vascular Disense disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 \( \subseteq \text{Yes} \quad 2 \subseteq \text{No} \) Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? λq 4 nknown Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed; 2 No 1 ☐ Yes of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification; To 1 Inpatient illed in by the funeral 28b. Time of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Director: 3 🗀 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) MYSICIAN 30. Name and address of person who completed dause of death (Item 23a) (Type, Print) Baltimore 21229 elmon, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 1 1 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death 8,2005 March **Physician** 1010 JAMES MICHARD /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Laston Talbot The Memorial Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
JULY 8, 1946 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 X M 2 □ F NEW YORK 58 213-46-0590 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County f show 10a. State or other treumatic event, the Madical Examinar must be notified at 1 **X**Yes 2 □ No QUEEN ANNE'S CENTREVILLE 286-1 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number -0 ā 21617 USA 709 LITTLE KIDWELL AVENUE \*naturel', or Items 23a Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Baltimore, Maryland 21215-0036 Specify: WHITE þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Heelih and Mental Hygiene. Importent: if tiem 27 is marked other than any injury or other treumatic event. If a Ma Elementary/Secondary (0-12) College (1-4or 5+) BANKING MORTGAGE PROCESSOR 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be VIRGINIA MARY SWIFT JAMES HENRY FLYNN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 709 LITTLE KIDWELL AVENUE, CENTREVILLE, MD 21617 KRISTIN N. FLYNN/ DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 XCremation 3 Removal from State CHESAPEAKE CREMATION CTR. 3-9-2005 STEVENSVILLE, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, Jentun 408 S. LIBERTY ST., CENTREVILLE, MD 21617 Mamor 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final foilure Respirato **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): to (or as a consequence of): End stage Chronic obstructive Lung disease to (or as a conservence of): Exacerbatron Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner the burial-transit that initiated events and resulting in death) Last Due to (or as a consequence of): Box 68760 signed by the attending physicien be Physician/Medical 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Records. Coronary ortery disease 1 Yes 2 No 3 Probably 4 Unknown peed bertenston 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 1 Yes 2 No of Vital funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ↑ Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Mann of Death 28b. Time of 28d. Describe how injury occurred After or Attending 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No s after death. investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 3-8-2005 Harou Laura -D55484 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HAIOU LAURA JIN, M.D., 219 S. WASHINGTON STREET, EASTON, MD 21601 32. Registra's Signature 31. Date filed (Month, Day, Year) State Registrar MAR 1 0 2000

			For State Registrar	State of M	laryland		rtment of F		Mental Hyو ر	giene	5 10272
			Decedent's Name (First, Middle, I	Last)			mouto or		2. Date of Dea		3. Time of Death
	Physici	an							Month	Day Ye	ar A
ŀ	/Medic		4a. Facility Name (If not institution,	5 urmer			4h City Town o	r Location of Deat	March	4c. County of D	33 11[0
	Examin	ier					40. Olly, 10411, 0				
			SHADY GROVE ADV		PIIAL ige (In yrs. las	st hirthday)	If Under 1 Year	ROCKVILI If Under 24 Hrs			NTGOMERY  Birthplace (State or Foreign
	Funeral Director		010-09-6770	1 <b>3</b> M 2 □ F	95		Months Days	Hours Min.		y, Year)	Birthplace (State or Foreign Country) NADA
			Usual Residence of Decedent							. 90 9 GF	IVADA
	yland		10a. State 10b. County		10c. City,	Town or Loca	ation				10d. Inside City Limits
	Mar Fe	ţċ	MD MO	ONTGOMERY			ROCKVII	LE			1 XYes 2 No
	h the	irec	10e. Street and Number				10f. Zip Code			10g. Citizen of What	Country?
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9	after or Itu	교	1 Never Married 2 Married		]No	4.5	Tes 2 No	Specify:	10 / 110411, 010.7	Specify: W	Vhite, etc. THTTE
21215-0036	ours	d b	3 XWidowed 4 □ Divorced	Year or Dates	: WW 2					Specify. 1	
5	72 h 'natu	ete	15. Decedent's (Specify only highest)	Education grade completed)		(Give ki	nt's Usual Occup	during most of wo	rking	16b. Kind of Busine	ess/Industry
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and	ba fi	Be	17. Father's Name (First, Middle, La	ist)						Maiden Sumame)	
Ž	ould Mer narka	P	SAMUEL GURMAN	(Torre Brief)		405 44-115-	A		SARAH SCH		7: 0 /
Maryland	12 st h and 7 Is n traun		19a. Informant's Name/Relationship			_				r, City or Town, Stat	
e,	1 and fealt sm 2	3	JOSEPH GURMAN —  20a. Method of Disposition	SUN			TORCH LA	ANE, SEA	BROOK, MA	ARY LAND 2 20c. Location - City	20206
Ö	No. = if		1 N Burial 2 ☐ Cremation 3		e cen	netery, crema	itory or other plac	1			
ij	tmer tant riant		`4 □Donation 5 □ Other (Spe		SHARC		L PARK		-	HARON, MA	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itama 23a or 28a-1 show any injury or other traumatic event, the Mcdical Examinet must be notified at once.		21. Signature of Funeral Service Lice	censee		ĔĎ	WARD SAG	EL FUNER	AL DIREC	TION, INC.	
	TO 2 4 0		(MAX)								YLAND 20852
ч			23a. Part 1. Enter the disease of co shock, or heart failure. List or	omplications that cause nly one cause on each	ed the death. line.	Do not enter	the mode of dyir	ng, such as cardia	c or respiratory ar	rest,	Approximate Interval Between Onset and Death
	Prysician		Immediate Cause (Final disease or condition	a. Nons	millell	Lune	Canca				4 4
	/Medical Examiner		resulting in death)	Due to (or a	is a conseque	nce of):					
П	-xammer	_	Sequentially list conditions,	b		0					
	pe is	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or a	s a conseque	nce or):					
	4 - 5		Contract If the contact of tritling								
	cact and I-tra	xam	Cause (Dispase or irijus) that initiated events resulting in death) Last	c. Due to (or a	s a conseque	nce of):					1
60,	be exact cian and burial-tra	ai Examiner	that initiated events	c Due to (or a	s a conseque	nce of):					
,8260,	cate be exacuted physician and the burial-transit	cai	that initiated events	cDue to (or a	s a conseque	nce of):					
x 68760,	sertificate be exact ding physician and sa as the burial-tra	cai	IF FEMALE:	d						201 Day of	
Box 68760,	eath certificate be exacu attending physician and for usa as the burial-tra	cai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	d	e of pregnanc	cy eath 3⊟E	ctopic pregnancy	,		23d. Date of Month	delivery Day Year
Вох 6	he death certificate be exact the attending physician and ched for usa as the burial-tra	cai	IF FEMALE: 23b. Was decedent pregnant	d	e of pregnanc	cy eath 3⊟E	ctopic pregnancy	,			
P.O. Box 6	that the death certificate be exact ed by the attending physician and detached for usa as the burial-tra	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown	d	e of pregnanc 2	eath 3⊟E th 5⊡0	Other (specify)		23e. Did to	Month	
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		-	For Stata Registrar	State of Ma	aryland		artmen <i>rtificat</i>			and M		giene Reg. No 20	05	1027	74
			1. Decedent's Name (First, Middle, Las	t)							2. Date of De Month	Day	Year	3. Time of Dea	
	Physici: /Medic		Mary Catherin	e Gordon	1						March	8, 200		5:05 a	М
>	Examin		4a. Facility Name (If not institution, give						Location o			4c. County			
			Calvert Memor	ial Hosp	oita1				Frede				Calv		- ion
	Funeral		5. Social Security Number 6. So	ex 7.Age □M 2⊠F	e (In yrs. las	st birthday) Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da	y, Year)	9. Birth	nplace (State or For untry) NY	eign
	Director		578-24-8706 Usual Residence of Decedent		80			_			12/3/	1924		1// 1	
	land		10a. State 10b. County		10c. City,	Town or Lo	ocation							10d. Inside City Lin	mits
	Mary 1 sh	호	MD Cal	vert				Dun	kirk				ĺ	1∭Yes 2 [	]No
	r 28a	rec	10e. Street and Number				10f. Zip	Code				10g. Citizen of	What Co	untry?	
	h with	Funeral Director	2704 Apple Way	7				20	754			U	SA		
	death	ner	11. Marital Status	12. Was Decedent B	Ever in U.S.	. 13.	Was Dece	dent of H	ispanic Orig	gin? (Spe	ecify Yes or No Rican, etc.)	- 14. Rad	ce - Amer	ncan Indian,	
9	after or tte	正	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 1 N If Yes, Give	No		1 ☐ Yes			•	,	Specif	v.		
ဋ	within 72 hours after death with the Maryland iene. r than "natural", or ttems 23a or 28a-f show the Medical Examinar must be rediffed at	d by	3 XWidowed 4 ☐ Divorced	Year or Dates:									WI	hite	
5	72 h natu	Completed	15. Decedent's Ed (Specify only highest gra			16a. Dece	dent's Usu kind of wo DO NOT u	ork done o	during most	t of worki	ing	16b. Kind of B	usiness/l	ndustry	
121	within ene. than *	ď	Elementary/Secondary (0-12)	College (1-4or 5	i+)	me.			" aker			Ow	n Ho	ome	
7	filled v Hygie other f		12 17. Father's Name (First, Middle, Last)					Jiicii		r's Name	(First, Middle	, Maiden Surnar			
and	ed at a se se se se se se se se se se se se se	Be							А	nna	Kozoi	1			
<u>&gt;</u>	d 2 should be th and Menta the marked traumatic ex	2	Neazy Zediack  19a. Informant's Name/Relationship (1)	Type, Print)	- 1	19b. Maili	ng Address	s (Street	and Numbe	er or Rura	al Route Numb	er, City or Town,	State, Z	ip Code)	
Maryland 21215-0036	2 6 7 6		R. Calvert Ste	uart/Att	orne	v 100	020 8	50.	Mary	1an	d Blvd	., Dun	kir	k, MD	
	s 1 and 2 of Health item 27	li	20a. Method of Disposition		20b. Pla	ice of Disponent	osition (Na.	me of		0	Date	20c. Location	- City or	Town, State	
<u>10</u>			1 🔀 Burial 2 □ Cremation 3 □  '4 □ Donation 5 □ Other (Specify		So.	. Men	noria	1 G	dns	3/14	4/2005	Dunki	rk,	MD	
Baltimore,	불로판단		21. Signature of Funeral Service Licer		,				ss of Facilit					., P.A.	
ñ	Dep Imp any	1	16. No			F	PO Bo	ox 4	30,	Dunl	cirk,	MD 207	54		
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused	the death.									Approximate Interval Between	ņ
10	Pnysician	, i	Immediate Cause (Final disease or condition		IYPO	XIF	<del>)</del> ,							Onset and Deat	л
	/Medical		resulting in death)	a.		2000 061:									
	Examiner		Cognostially list conditions	Ple	a conseque	u	4	25	100						
-	p #	ner	Sequentially list conditions, if any, leading to immediate cause. Liter Underlying Cause (Disease or injury	Due to (or as	a conseque	ence or):	1			006	CPC				
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90,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit		in the same of the	Due to (or as	a conseque	SitCO 01/.			•						
68760,	physic the t	Physician/Medical		d											
9 ×	leath certifical attending phi I for use as th	/Me	IF FEMALE:	23c. If yes, outcome	of pregnan	cy						23d. Da	ate of deli	verv	
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P.0.	that the de ed by the detached	ıysle	1 Yes 2 No 9 Unknown	9☐ Unknown			,								-100
	ires that the signed by detaction	by Pt	Part II. Other significant conditions of		ut not resul	ting in the u	underlying	cause giv	en in Part I.		23e. Did	obacco use con	tribute to	the cause of death	1?
ds	uid be	d b	Sm	okung							ue	Yes 2□No	3 ☐ Pro	obably 4 Unkn	own
Records,	aw requir ts been si 2 should	olete		<b>V</b>							24a. Was		Were au	topsy findings avail completion of cause	lable
Re	The tay te has age 2	Completed									perfo	ormed?	death?	212 No	,
Vital	ysician: The is certificate hadirector, page	BeC	25. Was case referred to medical						26. Place	of Deat	h (Check only				
>	Physician: this certificatal director, I	TO E	examiner? 1 Tes 2 No	Hospital Inpatie	ent 2 🗆 E	R/Outpatie	ent 3□ D	OA Oth	ier: 4 🗆 Nu	ursing Ho	me 5 🗆 Res	dence 6 Otl	ner (Spec	cify)	
Jo u	ding Ph n. After th funeral		27. Manner of Death Natural 5 Pending	28a. Date of Inju (Month, Da		28b. Time o Injury		28c. Injur Wor			28d. Describe	how injury occur	red		
Ö	Attending or death. ector: After by the fune	atic	2 Accident investigatio				М		Yes 2	No				15	
Division	or Att ter de irecte	Certification:	3 Suicide 6 Could not be determined	200. Place of m	ury - At hor c. <i>(Specify)</i>		treet, facto	ry, office		1	City or To		ser or Hu	ıral Route Number,	
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral				-4 · ·	dede - 1-	4b ====	d mb bb = 2*	ma det	nd class	and due to the	naucolal and	ancor a-	stated	
	Hosp 24 ho Fune tely fi	Medical	29a. Certifier UC Certifying Pl	nysician: To the best niner: On the basis o and manner st	f examinati	on and/or i	nvestigatio	n, in my c	ppinion, dea	ath occur	red at the time,	date and place,	and due	to the cause(s)	
	thin 2 the othe	Med	29b. Signature and title of certifier	and manner st	ateu.		29	c. Licens	e number			29d. Date signe	ed (Monti	h, Day, Year)	
	To vit		_	lendony	> .			De	060	63	8	3/9/1	25	,	
7			, , , ,		4	23a) (Tvoe	, Print)	110	HOS	PIT	AL R	DAN			
	4		30. Name and address of person who	Mendor	COL	, M.	D.	1	PRIN	CE	FR	2 G DER	104	3067	8
	St	ate	31. Date filled (Month, Day, Year)	32. Registr	rar's Signat	ure									
	Regist	trar	MAR 1 U 2005 🔏	Temper,	GOL	and I									

	1 - Stata Registra		State of I			rtificat				R	eg. No.	11115	10	27
্⊅ Physiciar		s Name (First, Middle, L	JAMES	CDT	GSBY				- 1	2. Date of Dea Month	Day	Year		of Death
/Medica		NORRIS			-GSD1	4h Cih	Tours	Location of [		MARCH 4		005 County of Death	7:48	8 A
xamine		ame (If not institution, gi				40. Oity,		hever:			40.0	Prince		7010
neral		urity Number 6.	Sex 7.		last birthday)		r 1 Year	If Under 24	Hrs. 8	B. Date of Birth (Month, Day	Vone		place (State	
ector	577-44	i-7306	1 ★ M 2 □ F	71	Yrs.	Months	Days	Hours	Min.	May 8,	1933	3 Sou	th Car	colin
	Usual Reside	10b. County		10c. Ci	ty, Town or Lo	ocation							10d. Inside	City Limi
ied a		1 D	01.					T						es 2 🗆 N
the Madical Examinatinative nutified at	10e. Street a	and Prince	George S			10f. Zip	Code	Largo		1	0g. Citize	en of What Coa	untry?	
ist is	2	8902 Congre	ss Place					20786	6		Ur	nited S	tates	
Europe a	11. Marital S	tatus	12. Was Decede Armed Force		.S. 13.	Was Dece If Yes, spe	dent of His	spanic Origin n, Mexican, F	? (Spec Puerto Ri	fy Yes or No- can, etc.)	14	4. Race - Amer Black, White		
by E	1 Neve	er Married 2XXMarried	1X Yes 2(			1 🔲 Yes		Specify:			5		lack	
1 2	3 Wild	15. Decedent's E	Year or Date	5.	16a. Dece	dent's Usu	al Occupa	tion			16b. Kin	d of Business/li	ndustry	
A POINT	Sia-satar	(Specify only highest gay)/Secondary (0-12)	rade completed) College (1-4d	25.1	(Give	kind of wo DO NOT u	ork done di	uring most of	f working	7		- 0. 200110001	iloudity	
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	2	Lamar G			-							Willi:		
other treumatic		int's Name/Relationship				-					-	Town, State, Zi 7er, MD		25
2		es J. Grigs of Disposition	by - 5011	20b. F	Place of Dispo			a Ave	• • 17 .	-		ation - City or T		
eny injury or o once.	1 🗷 Bur	al 2 Cremation 3		te	cemetery, crei	matory or o	other place	.						
		ation 5 Other (Spec e of Funeral Service Lice		Qua	ntico							iangle 11 Home	, VA	
eny ii		late T	Stoward	111								, DC 20	0019	
cal ner dimeritansii	Immediate disease or resulting in a sequentially if any, leading cause. Ente Cause (Disease in that initiated resulting in a sequentially in the sequential initiated resulting in a sequential initiated resulting initiated resulting in a sequential initiated resulting initiated resulting initiated resulting initiated	list conditions, to immediate r Underlying ase or injury events	b. Due to (or	as a consec	Quence of):  CART DI  Quence of):	SEASI	3							
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2 8	2	aignineant conditions	continuoung to death	i bat not res	anting in the d	riderlying c	Jausa giva	iliiraiti.				No 3 Pro		
age 2 should									_	24a. Wasa	0	24b. Were aut	ansy finding	e availah
page z		-								autops	y Red?	death?	ompletion of	cause of
io. bg	)	e referred to medical						26 Place of	Death (	1 ☐ Yes : Check only on	No No	1 🗆 Yes	261 No	
direct	ayamine Yes	r? 2	Hospital: 1 ☐ Inpa	atient 2	ER/Outpatier	nt 3 🗆 D0	Othe					Other (Speci	ifv)	
neral			28a. Date of I (Month,	nj <i>u</i> ry Day Year)	28b. Time o	f 2	28c. Injury Work	at ?		d. Describe h				
the fun	2 Acc	dent investigati	on			М		es 2 No						
	3 Suic 4 Hon		4 286. Place of	Injury - At h etc. (Special	ome, farm, str fy)	eet, factor	y, office		28	f. Location (Si City or Town		Number or Rur	al Route Nu	mber,
100	29a. Certifie (Check one)	r 1 Certifying F	hysician: To the be miner: On the basis and manner	s of examina	owledge, deat ation and/or in	h occurred vestigation	at the time n, in my op	e, date and p inion, death	olace, an	d due to the call at the time, d	ause(s) a ate and p	nd manner as : place, and due !	stated. to the cause	(s)
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	ysicia Medic		Ovilla Raymond Guilbault				Month Murc	Lio, wo	5 16:50 PM
	amin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	7-000 (-	4c. County of Dea	
			194 W. Red Hill Road		Conowi			Cecil	
Fun Dire	eral ctor		035-20-7946 1 <sup>™</sup> M 2□F	(In yrs. last birthday) 75 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, )ctober	Year) Co	thplace (State or Foreign buntry) RI
and			Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits
Maryl 1 sho	E S	ō	MD Cecil	Conowin					1 ☐ Yes 2 🛣 No
the	To the	Director	10e. Street and Number	CONOWAN	10f. Zip Code		10	0g. Citizen of What Co	ountry?
h with	2		194 W. Red Hill Road		21918			USA	
deat	8	Funerai	11. Marital Status 12. Was Decedent 9 Armed Forces?	ever in U.S. 13.		ispanic Origin? (Spe n, Mexican, Puerto I	cify Yes or No-	14. Race - Ame	
at y rating Z i Z i Z i Z i Z i Z i Z i Z i Z i Z	other treumatic event, the Medical Examinar must be notified at	by	1 Never Married 2X Married 1X Yes 2 N 3 Widowed 4 Divorced 1X Yes, Give Year or Dates:	0	1 ☐ Yes 2 ☐Xio	Specify:	nicari, etc.)	Specify: W	
72 hg	dice	etec	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occupa	ation during most of working	na I	16b. Kind of Business	/industry
vithin ne.	8 P	Completed	Elementary/Secondary (0-12) College (1-4or 5	+) life. I	DO NOT use retired	)			
illed v Hygie ther t	ii.		17. Father's Name (First, Middle, Last)	Sup	erintende	18. Mother's Name	/Eirst Middle A	Construct	ion
2 should be filed within and Mental Hygiene. Is marked other than	C BVB	o Be	Ovilla Joseph Guilbault					raiden Sumame)	
shoul nd Me	mati	유	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street a	Ellen K and Number or Rura	The second secon	City or Town, State, a	Zin Code)
	ir trei		Bethly Guilbault/Wife					, MD 2191	
S 1 a of Hei	othe		20a. Method of Disposition	20b. Place of Dispo	sition (Name of natory or other plac	D	ate 2	20c. Location - City or	Town, State
Page nent c	ury or		1	Delaware		103-16	-2005	Bear, DE	
permit. Pages 1 and 2 Department of Health a	any inj		21. Signature of Funeral Service Licensee	/ • 22	2. Name and Addres	en St., K	. Foard	Funeral H	
			23a. Part1. Enter the disease, or complications ha caused	the death. Do not ent					911 Approximate
Physic	cian		shock, or heart failure. List only one cause or each lin Immediate Cause (Final disease or condition	000	n				Interval Between Onset and Death
/Med	lical		resulting in death)	a consequence of):	V				fears
Exam	iner		Sequentially list conditions, b.						
D	sit	Examiner	if any, leading to immediate Due to (or as a cause. Enter Underlying	a consequence of):					
and	-tran	хаш	that initiated events c. Pue to (or as:	a consequence of);					
be eg	buria	aiE	535 10 (57 83 )	a consequence or,					
ficate	s the	edicai	d						
sonding	for use as the burial-transit		IF FEMALE: 23c. If yes, outcome					23d. Date of del	iverv
ne death	hed for	Physician/M	in the past 12 months?  1 Yes 2 No 9 Unknown		Ectopic pregnancy Other (specify)			Month	Day Year
that the	ac		Part II. Other significant conditions contributing to death but	it not resulting in the u	nderlying cause give	on in Part I	23e Did tob	acco use contribute to	the cause of death?
To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending physician and	should be	ted by					1/2 Yes		obably 4 Dunknown
slcien: The law r	N	ompleted					24a. Was an autopsy perform	/ prior to	topsy findings available completion of cause of
n: Th	by the funeral director, page	e Co	25. Was case referred to medical				1  Yes 2	No 1□Yes	2□ No
scerti	lirecto	o Be	25. Was case referred to medical examiner?  1  Yes	nt 2 ER/Outpatien	it 3□ DOA Othe	26. Place of Death			
Phys	eral	-	27. Manner of Death 28a. Date of Injur	y 28b. Time of				nce 6 Other (Spec w injury occurred	cify)
ath.	e fun	atio	1 Natural 5 □ Pending (Month, Day 2 □ Accident investigation	Year) Injury		(? /es 2 □ No			
To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A	in by th	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Inju building, etc	iry - At home, farm, stre . (Specify)	eet, factory, office	2	8f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
spitel	/ filled		29a. Certifier 1 Certifying Physician: To the best of	of my knowledge, death	occurred at the time	e. date and place. a	nd due to the car	use(s) and manner as	stated
he Ho in 24 t he Fu	completely filled in	edical	(Check only 2 Medical Examiner: On the basis of one) and manner sta	examination and/or inv	vestigation, in my op	pinion, death occurre	d at the time, da	te and place, and due	to the cause(s)
To t To t	con	Σ	29b. Signature and title of certifier		29c. License	number	29	d. Date signed (Monti	h, Day, Year)
	X		If former, MD		719	5314	N	100ch 11,	2005
100	76,		30. Name and address of person who completed cause of de	1	Print)	/	6 1		kton, MD
سنر	Sta	te	31. Date filed (Month, Day, Year) 32. Registra	s Signature	ern a	es apr	Ne 1703	pice, t/	K1011, /1)
Re	عاد gistr	,	MAR 1 4 2005	A Anne					

			State of Maryland /	Department of Health and Mer		
		i	1 - State Registrar	Certificate of Death	Reg. No. 200	5 10278
	Dhysisi	25	Decedent's Name (First, Middle, Last)	2.	Date of Death Month Day Yeer	3. Time of Death
	Physici /Medio		Marion B. Gobrecht		3 100.	5045 M
	Examir	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of De	ain
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last)	birthday) If Under 1 Year II Under 24 Hrs. 8.		inthplace (State or Foreign
	Director		196284137 10M24 91	Yrs. Months Days Hours Min.	Date of Birth (Month, Day, Year)	PA
	and w.		Usual Residence of Decedent           10a. State         10b. County         10c. City, To	own or Location		10d. Inside City Limits
	Maryl -f sho	tor	MD Kent Gol	ts		1 □Yes 2√ No
	th the or 28a	Jirec	10e. Street and Number	10f. Zip Code	10g. Citizen of What 0	country?
	ath wi	rai	13618 Golts Caldwell Road	21635	u.s.A.	
	ter de	Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married  1 □ Yes 2 □ No	13. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Ric	y Yes or No- an, etc.) 14. Race - An Black, Wh	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show the Modical Examinating the multiple at	by	3 ☐ Widowed 4 ☑ Divorced Year or Dates:	1 ☐ Yes 2 ☐ No Specify:	Specify: W	rite
2-0	72 ho	Completed	15. Decedent's Education 16 (Specify only highest grade completed)	Sa. Decedent's Usual Occupation (Give kind of work done during most of working	16b. Kind of Busines	s/industry
121	within iene. than '	mpi	Elementary/Secondary (0-12) College (1-4or 5+)	iffe. DO NOT use retired)  Hotel Owner	Hotel	
<b>d</b> 2	filled Hygie other ent,	Be Co	17. Father's Name (First, Middle, Last)		irst, Middle, Maiden Sumame)	
ılan	Mental Mental arked o	To B	Benjamin Bowen	Lucille	Moene	
Maryland	2 shc and is m			9b. Mailing Address (Street and Number or Rural R		
	1 and Health tem 27 other tr			13618 Golts Caldwell Room of Disposition (Name of Date		
nor	Pages nent of I nnt: If It ury or o		1 ☐ Burial 2 XCremation 3 ☐ Removal from State	tery, crematory or other place) Ferris Crematory 3-14-:		
Baltimore,	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Licensee		Foard Funeral H	
m	Deg Im gang		Keepard L. Goodie	111 S. Quenn St., Ri		
			23a. Part   Enter the disease, or complication , that caused he death. D shoot, or heart failure. List only one cause on each lin.	o not enter the mode of dying, such as cardiac or re	espiratory arrest,	Approximate Interval Between Onset and Death
	Physician			RATORY FAILURE		12 HOURS
	/Medical Examiner		PNFU	MONIA		
	- 13	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.			
29	nd nd transit	Examiner	Cause (Disease or injury that initiated events c			
,092	ate be executed hysician and he burial-transit	cai Ex	resulting in death) Last Due to (or as a consequence	ee o1):		
687	icate physics the l		d			
Box (	The law requires that the death certifica ite has been signed by the attending ph bage 2 should be delached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetel dec		23d. Date of d	•
. B	a death	sicia	1 Yes 2 No 4 Pregnant at time of death		Month	Day Year
P.O.	hat thi	Phy	9 ☐ Unknown  Part II. Other significant conditions contributing to death but not resulting	g in the underlying cause given in Part I.	23e. Did tobacco use contribute	to the cause of death?
Records,	uires t signe	Completed by	CHRONIC OBSTRUCTIVE PULMON		1 ☐ Yes 2 ☐ No 3 ☐ I	4
CO	s been si s should?	ojete	MYOCARDIAL INFARCTIO	N	24a. Was an 24b. Were	autopsy findings available
Re	The ta	mo			autopsy prior to death?  1 Yes 2 No 1 Yes	
Vital	cien: ertifica ector,	Be	25. Was case referred to medical examiner?	26. Place of Death (C	theck only one)	
of \	Physicien: this certificated director,	2			5 Residence 6 Other (Sp.	ecify)
on	ding I h. After funer	tion	27. Manner of Death  1 Natural 5 Pending (Month, Day Year)  2 Accident investigation	28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No	. Describe now injury occurred	
Division	Attendil ar death. ector: A by the fu	ifica	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  6 ☐ Could not be determined building, etc. (Specify)	farm, street, factory, office 28f.	Location (Street and Number or I City or Town, State)	Rural Route Number,
Ö	itel or rs afte rel Dir led in	Cert				
	To the Hospitel or Attending Physicien: The law within 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Medical Certification:	29a. Certifier 1 ☐ Certifying Physician: To the best of my knowled (Check only one) 1 ☐ Medical Examiner: On the basis of examination and manner stated.	ige, death occurred at the time, date and place, and and/or investigation, in my opinion, death occurred to	due to the cause(s) and manner at the time, date and place, and di	as stated. ue to the cause(s)
	o the	Med	29b. Signature and title of certifier	29c. License number	29d. Date signed (Mo	nth, Day, Year)
	~ > P O		Naveluple M.D	D0051197	MARCH 10,	2005
•	5		30. Name and address of person who completed cause of death (Item 23:	a) (Type, Print)	~ ~ ~ ~	0:= ::
			MAYA Û() PTA 110 W  31. Date filed (Month, Day, Year)   \$2. Registrar's Signature		WILMINGTON )	NE 14801
	Sta Regist		MAR 1 4 2005	fort		

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** HOWARD EUGENEGIBSON 0930 AM 2005 MAKEN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** KENT HALL LLENDALE LARM KOCK If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F 73 January GĂ 255-40-5445 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f ehow other treumetic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 No MDKent Rock Hall 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code or items 23e or 4080 Ellendale Farm Drive 21661 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. permit Pages 1 and 2 should be filed within 72 hours after o Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or iten any injury or other treumetic event, the Medical Examina Black, White, etc. Amed Folces: 1∑Yes 2☐No If Yes, Give Year or Dates: 1958 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Store Owner Retail 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Cliff Gibson Audrey Reece 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carole Ann Gibson/Wife 4080 Ellendale Farm Dr., Rock Hall, MD 21661 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Chesapeake Cremation March10,2005 Stevensville, MD ` 4 ☐ Donation 5 ☐ Other (Specify) <sup>22</sup> Name and Address of Facility FEIlows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, MD 21620 21. Signature of Funeral Service Licenses brow Teller 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Squamous Cell CARNINDMA, Pharing, Esophogen's
Due to (or as a consequence of): Physician yrs disease or condition resulting in death) /Medical **Examiner** -ARCINOMA IN SITU, epislettis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed burial-transit and Due to (or as a consequence of): physician Box 68760 Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ Abetes Mellitus 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No pertension certificate has ASCVD 2 10 No 1 Yes Hospitel or Attending Physicien: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Amesidence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28c. Injury at Work? 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending within 24 hours after death. To the Funerel Director: Al 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D19322 Muna 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rock Hall Medrol Center RockHall, MD 21661 FOWARD E. Wilson MD 32. Registrar's Signature State 1 2005

DHMH 17 Rev 1/200

Registrar

	1 - For State Registrar		State of	Marylan	•	artmen rtificate			and M		Reg. No		5	102	80
ataunia inu	1. Decedent's Nan	ne (First, Middle, Last,	)							2. Date of De Month	ath Day	, Y	ear	3. Time o	of Death
Physician /Medical		George		Wi1	son		ross			March	4,	200		8:40	РМ
Examiner	4a. Facility Name	(If not institution, give	street and numb	oer)		4b. City,	Town, or	Location of	of Death		4c.	County of	Death		
	15508	Baltimore Pik	ke, N.E.				mber]					Allega			
uneral irector	5. Social Security 214-14-74	33 10	X M 2□F	Age (In yrs. 86	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Bir (Month, Da 11/06/19	th ly, Year) 918	9	. Birthpl Coun Mary 1	ace (State of try) Land	or Foreigr
3	Usual Residence	of Decedent 10b. County		10c. Cit	y, Town or Lo	cation							10	Od. Inside C	City Limits
or or	MD	Allegany	7			erland									s 2 🖔 No
r itema 23a or 28a-f si rit scrimust be notified Funeral Director	10e. Street and No	umber				10f. Zip	Code		-		10g. Cit	izen of Wh	at Coun	try?	
2 0 E	15508	8 Baltimore H	Pike, N.E.				2150	02				USA			
ma 2; Imma	11. Marital Status		12. Was Deced	ent Ever in U.	.S. 13.	Was Deced	lent of Hi	spanic Ori	gin? (Spe	ecify Yes or No Rican, etc.)	)-	14. Race -			
Fur	1 Never Ma	rried 2 X Married	Armed Ford	Mo		fYes, spec 1 ☐ Yes :				Rican, etc.)			White, 6	etc.	
Errar.	3 Widowed	4 Divorced	If Yes, Give Year or Dat	es:		1∟ Yes a	2 <b>(</b> ) No	Specify:		_		Specify:	V	Mhite	
lical lical	(Spe	15. Decedent's Edu	ication le completed)		(Give	dent's Usua kind of wor	rk done a	turina mos	t of worki	ing	16b. K	ind of Busi	ness/Inc	lustry	
t, the Medical E	Elementary/Sec		College (1-4	for 5+)	life.	DO NOT us	e retired	)							
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<b>=</b> -		(First, Middle, Last)		Wilson	C	ross		18. Mothe		(First, Middle	, maiden		⊦1 <i>:-</i>		
narked o	Oli			wilson		ross	(0)			(D- : : :	0"		tling	<u> </u>	
raum		Name/Relationship (T)	• •			-				I Route Numb	-			Code)	
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ant: if ite	20a. Method of Di	sposition 2 □ Cremation 3 □ F	Removal from St	ale	Place of Dispo emetery, crei					1			-		
jury		5 Other (Specify)		Mo	unt Hen				03/08,			mberla	,		
Important: if item 27 any injury or other tr once.	21. Signature of	uneral Service Licens	1	)	22					ms Family Cumberlar				P.A.	
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hysician and he burial-transit	Sequentially list of any, leading to cause. Enver Unit Cause (Disease of that initiated even resulting in death	conditions, immediate seriying or injury	b. Due to (o	r as a conseq r as a conseq r as a conseq	uence of):										
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be d	Part II. Other sign	nificant conditions co	ntributing to dea	th but not res	ulting in the u	nderlying c	ause give	en in Part I						e cause of ably 4	
cate has been si page 2 should Completed												pride	or to con ath?	osy findings npletion of a	available cause of
is certificate director, pag To Be Col	25. Was case reference?	-								(Check only o	_				
Σ ₽ C	1 ☐ Yes 2	(140		patient 2						me 5 🖾 Resi				1)	
After th funeral	27. Manner of De 1 X Natural	ath 5 Pending	28a. Date of (Month)	Injury Day Year)	28b. Time o Injury		8c. Injury Work			28d. Describe	how inju	y occurred			
or: Aft the fur catio	2 Accident	investigation				М	10	Yes 2□	1						
al Director: After to the in by the funeral Certification;	3 🗍 Suicide 4 🗍 Homicide	determined	28e. Place c	of Injury - At high etc. (Specif	ome, farm, st (y)	reet, factory	, office			28f. Location ( City or To	Street an wn, State	d Number )	or Rura	l Route Nun	nber,
To the Funeral Director: completely filled in by the Medical Certifical	29a. Certifier (Check only one)	1 ☐ Certifying Phy 2 ☐ Medical Exem	iner: On the bas	is of examina	owledge, deat ation and/or in	h occurred vestigation	at the tim , in my op	ne, date an pinion, dea	nd place, ith occurr	and due to the ed at the time,	cause(s) date and	and mann place, and	er as st d due to	ated. the cause(	(s)
omp Me	29b. Signature ar	nd title of certifier		/		290	. License	number			29d. Da	te signed (	Month, I	Day, Year)	
			My				D22	280		1	Ma	rch 7,	200	5	
	, , , , , , , , , , , , , , , , , , ,		11				D33	200			110	TCII / 9	200	_	
3	30. Name and ad	dress of person who c	pinpleted cause	of death (Item	n 23a) (Type.	Print)		200			116	,	200		
		dress of person who c	V		n 23a) (Type, ent Aver				Mary la	and 2150		,	200		

			For	State of Ma	aryland	-				and Me	ental Hy	giene			
			Stete Registrer			Cei	tificat	e of L	Death	- 1 -		Reg. No.	2005	102	189
	Physici	an	Decedent's Name (First, Middle, Last)								2. Date of Dea	Day	Year	3. Time of I	
	/Medic	al	Ray Randa11  4a. Facility Name (If not institution, give	George			4h City	Town or	Location of		arch_	9	2005 County of Death	6:15	AM
	Examin	er	Shady Grove Adver		nital			ockv		Death		1	Montgom	erv	
	Funeral					ast birthday)	If Under	1 Year	tf Under 2	24 Hrs. 8	B. Date of Birt			place (State or ntry)	Foreign
	Director		413-03-3270 Usual Residence of Decedent	x 7. Ag ∃M 2□F	89	Yrs.	Months	Days	Hours	Min.	B. Date of Birt (Month, Da arch 1	5, 1	915 Ohi	) O	
	land we		10a. State 10b. County		10c. City	, Town or Lo	cation							IOd. Inside City	y Limits
	Mary If sh	tor	Maryland Montgom	ery	Gai	thers	burg							1 🗆 Yes	2 🙀 №
	h the	Funeral Director	10e. Street and Number				10f. Zip	Code				10g. Citi:	zen of What Cou	ntry?	
	th wit	al D	16625 Alden Aven	ue				208	77			Un	ited Sta	tes	
	r dea	Juer	11. Marital Status	12. Was Decedent Armed Forces?		3. 13.	Was Deced	dent of His	spanic Orig n, Mexican,	gin? (Speci , Puerto Ri	fy Yes or No can, etc.)	-	14. Race - Ameri Black, White,		
36	s afte	by Fi	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔯 N If Yes, Give Year or Dates:	No		1 □ Yes	2 📉 No	Specify:				Specify: T.T.	440	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. sther than "natural", or Items 23a or 28s-1 show stri, the Madical Examinat must be notified at	ed k	15. Decedent's Edu			16a. Deced	tent's Usua	al Occupa	ition			16b. Kir	MII nd of Business/In	ite	
715	nin 72 n "ne	plet	(Specify only highest grad Elementary/Secondary (0-12)		(4)	(Give life. l	kind of wo DO NOT us	rk done d se retired)	uring most	of working	7			,	
2	d with giene gritha	Completed	Liementary/Secondary (0-12)	4		Mechar	nical	Eng	ineer			Eng	ineering	3	
2	al Hy d othe	Be (	17. Father's Name (First, Middle, Last)								First, Middle,				
Х	should be to and Mental I is marked o umatic eve	To	Everett Elwood (								bertin				
Maryland	C1 10 = 68		19a. Informant's Name/Relationship (T) Vivian Viola Brog		Wife							-	r Town, State, Zip Marylan		7
	1 and Health em 27 ither tr		20a. Method of Disposition	George /		ace of Dispo				Dai	-		cation - City or To		<u></u>
Baltimore,	Pages nent of h		1 Burial 2 ☐ Cremation 3 ☐ F  4 ☐ Donation 5 ☐ Other (Specify)						1 11	farch 2005	14,		dhurst,		
₫	nit. Partme ortan injur		21. Signature of Funeral Servis Livers		urrı	lside 22					ol Fund			14.0.	
ä	permit. Departr Imports any inj	( 10	TRACUA A	un									ourg, MD	20877	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused	the death.									Approximate Interval Betw	/een
H	Physician		tmmediate Cause (Final disease or condition			nra	)							Onset and D	
	/Medical Examiner		resulting in death)	Due to (or as										0.43	
	- Xaiiiiiei	_		b. Due to (or as	2 222222	once of									
	led	nlne	if any, leading to immediate cause. Enter Underlying Cause (Disease or Lijus)	Due to (or as	a consequ	ence or):									
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760,	ate be executed hysician and the burial-transit	cal		d											
89	rtifical ng phy as th		IE EE MAN E.												
Вох	leath certific attending p I for use as f	an/I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. tf yes, outcome 1 ☐ Live birth			Ectopic pr	egnancy				2	23d. Date of delive Month	•	ear
0.	The law requires that the death certificate be executed tte has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	1 Yes 2 No	4□Pregnant at 9□Unknown	time of de	ath 5□	Other (sp	ecity)					WORTH	Day 16	bai
0	es that thigned by	Ph)	Part II. Other significant conditions co	ntributing to death b	ut not resul	ltina in the u	nderlvina c	ause give	n in Part I.		23e. Did to	bacco u	se contribute to t	ne cause of de	ath?
Records,	uires sign d be	d by	Meckel cell	tumor		_	, ,				1 🗆 ነ	es 2[	]No 3∏Prot	ably 4 🗹	nknown
S	w require been sign should b	lete	Hydrocrobali	10							24a. Was	an	24b. Were auto	osv findings a	vailable
Re	The la	Completed	11301 0 CCD11001	<i></i>						_		rmed?	prior to co death?	mpletion of car 2□ No	
ta	lan: Trifica	Be C	25. Was case referred to medical						26. Place	of Death (	1∐ Yes Check only o	2 ⊿No ne)	14165	2L1 NO	
>	Phyaician: r this certifica ral director, I	To E	examiner? 1 Yes 2 No	Hospital: 1 Inpatie	nt 2 🗆 E	R/Outpatien	t 3 🗆 DC	Othe	r: 4 🗆 Nur	rsing Home	5 Resid	lence 6	o □Other (Specif	y)	
0	e Te		27. Mann of Death 1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year)	28b. Time of Injury		8c. Injury Work			d. Describe h	ow injury	occurred /		
<u>s</u>	death.	catl	2 Accident investigation 3 Suicide 6 Could not be	00 Pl (1)			М		′es 2□N		6 h hi /r			10	
Division of Vital	after of Direction by	Certification:	4 Homicide determined	28e. Place of tnj buitding, et	ury - At hor c. <i>(Specify)</i>	ne, tarm, str	eet, factory	, office		28	City or Tou	m, State)	d Number or Rura	II Houte Numb	er,
_	spital		29a. Certifier 1 Certifying Phy	sician: To the best	of my know	vledge, death	occurred	at the tim	e, date and	d place, an	d due to the	cause(s)	and manner as s	tated.	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical	(Check only 2 Medicat Exemione)	iner: On the basis of and manner sta	examinati	on and/or inv	estigation.	, in my op	inion, death	h occurred	at the time,	date and	place, and due to	the cause(s)	
	To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Al completely filled in by the fu	Σ	29b. Signature and title of certifier	0		`		. License					e signed (Month,		~
)	10		・へた	100h	~1	1		). 2	-012	4 8		111	larch,	2001	5
	140		30. Name and address of person who co	ompleted cause of d		all	0 110	schl	Avo	e , ۱	G zith.	ersb	urg M	d. 20	879
	Sta Registr		31. Date filed (Month, Day, Year)  MAR 1 1 20	32. registra	ar's Signati	ure /	ale .								

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## Country   Cou			ROBERT	C. HU	NT						1911
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Security   Security			259-60-7129 X			Months		in. (Month, Da	y, Year)	Cour	ntry)
17. Father's Name (First, Middle, Last)   19b. Mailing Address (Streat and Number or Paural Route Number, City or Town, State, Zip Code)	show	_	10a. State 10b. County		10c. City, Tow	n or Location				1	10d. Inside City
17. Father's Name (First, Middle, Last)   19b. Mailing Address (Streat and Number or Paural Route Number, City or Town, State, Zip Code)	28a-1	ecto		set		406.70			10 011		
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1   Dural   2   Zigramation   3   Removal from State	otha vant,	Se C	17. Father's Name (First, Middle, Last)				18. Mother's N	lame (First, Middle,	Maiden		-
1   Blurial   2   2   2   2   2   2   2   2   2	rked rice	0	Norman P. Hunt				Doroth	ny Jones			
Care of the part	and a	ľ	19a. Informant's Name/Relationship (Ty	vpe, Print)	196	. Mailing Address	(Street and Number or	Rural Route Number	er, City or	Town, State, Zip	Code)
Carried Part   Continue   Carried Part   Carried	n 27 i		Janice Hunt (Wife)					nue - Cr	isfic	ld. MD	21817
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23a. Part I. Erifs the disease, or complications that caused the death. Do not effect the mode of dying, such as cardiac or respiratory arrest. Approximation from the mode of dying, such as cardiac or respiratory arrest. Approximation from the mode of dying, such as cardiac or respiratory arrest. Approximation from the mode of dying, such as cardiac or respiratory arrest. Approximation from the mode of dying, such as cardiac or respiratory arrest. Approximation from the mode of dying, such as cardiac or respiratory arrest. Approximation from the mode of dying, such as cardiac or respiratory arrest. Approximation from the mode of dying, such as cardiac or respiratory arrest. Approximation from the mode of dying, such as cardiac or respiratory arrest. Approximation from the mode of dying, such as cardiac or respiratory arrest. Approximation from the mode of dying, such as cardiac or respiratory arrest. Approximation from the mode of dying, such as cardiac or respiratory arrest. Approximation from the mode of dying, such as cardiac or respiratory arrest. Approximation from the mode of dying, such as cardiac or respiratory arrest. Approximation from the mode of dying, such as cardiac or respiratory arrest. Approximation from the mode of dying such as cardiac or respiratory arrest. Approximation from the mode of dying such as cardiac or respiratory arrest. Approximation from the mode of dying such as cardiac or respiratory arrest. Approximation from the mode of dying such as cardiac or respiratory arrest. Approximation and the mode of dying such as cardiac or respiratory arrest. Approximation from the mode of dying such as cardiac or respiratory arrest. Approximation and the mode of dying such as cardiac or respiratory arrest. Approximation and the mode of dying such as cardiac or respiratory arrest. Approximation and the mode of dying such as cardiac or respiratory arrest. Approximation and the mode of dying such as cardiac or respiratory arrest. Approximation and the mode of dying such as cardiac or respiratory. A	5 5 5 3		Mary Beth Brad	shaw-Pruit	au					MD 21	817
Interest of the part of the			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	lications that caused ne cause on each line	the death. Do e.	not enter the mode	e of dying, such as card	liac or respiratory a	rrest,		Approximate Interval Between
Due to (or as a consequence of):    Sequentially list conditions, if any, leading to immediate cause. Enter Underlying   Carried Part   Cause Enter Underlying   Carried Part   Cause Enter Underlying   Carried Part   Cause Enter Underlying   Carried Part   Cause Enter Underlying   Carried Part   Cause Enter Underlying   Carried Part   Cause Enter Underlying   Carried Part   Cause Enter Underlying   Carried Part   Cause Enter Underlying   Cause	ysician		disease or condition	Seal	tii I	hack	-				Onset and De
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d.    IFFEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 3   Probably 4   Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    23c. If yes, outcome of pregnancy 1   Livie birth 2   Fetal death 3   Ectopic pregnancy   Month Day   Month Day	aminer	L.	Sequentially list conditions,	ь.		ena					
d.    IFFEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 3   Probably 4   Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    23c. If yes, outcome of pregnancy 1   Livie birth 2   Fetal death 3   Ectopic pregnancy   Month Day   Month Day		liner	if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequence	of):					
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24a. Was an autopsy findings performed? 1   Yes   2   No   3   Plobably 4-2   24a. Was an autopsy performed? 1   Yes   2   No   25. Was case referred to medical examiner? 1   Yes   2   No   25. Was case referred to medical examiner? 1   Yes   2   No   26. Place of Death (Check only one) 4   Nursing Home   5   Residence   6   Other (Specify)  27. Manner of Death   28a. Date of Injury   28b. Time of Injury   28c. Injury at Work? 28a. Date of Injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural Route Num City or Town, State)  29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 28b. Place of Injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural Route Num City or Town, State)  29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Time of Injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural Route Num City or Town, State)	ttending physician and or use as the burial-transit	Examin	if any, leading to immediate cause. Enter Underlying Causes (Useese or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	Due to (or as a  d.  23c. If yes, outcome of the control of the co	consequence of pregnancy	of):			2		,
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25. Was case referred to medical examiner?  1 Yes 2 No  1 Yes 2 No  27. Manner of Death 1 Natural 2 Not North, Day Year)  28a. Date of Injury 28b. Time of Injury 4 North, Day Year)  28b. Time of Injury 4 North, Day Year)  28c. Injury at Work? M 1 Yes 2 No  28d. Describe how injury occurred  28d.	been signed by the attending physician and should be detached for use as the burial-transit	by Physician/Medical Examin	If any, leading to immediate cause. Enter Underlying Cause Use of him that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a d.  23c. If yes, outcome of 1 Live birth 2 4 Pregnant at t 9 Unknown	of pregnancy    Fetal death	of):  n 3 □Ectopic pre 5 □ Other (spe	ecify)	1 □ \	obacco us	Month se contribute to th No 3 ☐ Prob	Day Ye
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2 Accident 3 Suicide 4 Homicide 5 Could not be determined 6 Could not be building, etc. (Specify)  28e. Place of Injury - At home, farm, street, factory, office City or Town, State)  28f. Location (Street and Number or Rural Route Num City or Town, State)  28g. Place of Injury - At home, farm, street, factory, office City or Town, State)  29a. Certifier (Check only one) Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	s certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-transit	o Be Completed by Physician/Medical Examin	if any, leading to immediate cause. Enter Underlying Cause Use of him that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a d.  23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown ontributing to death bu	of pregnancy 2 Fetal death time of death at not resulting i	of):  a 3 Ectopic pre 5 Other (spe	ause given in Part I.  26. Place of C	24a. Was autor perio 1 Yes	es 2 an an an an an an an an an an an an an	Month se contribute to the No 3 Prob 24b. Were autor prior to condeath? 1 Yes	Day Ye ne cause of dea pably 4-Un psy findings av mpletion of cau 2 \( \) No
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29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	ctor: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical Examin	if any, leading to immediate cause. Enter Underlying Cause. Disease of him that initiated events that initiated events tresulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a d	of pregnancy 2 Fetal death time of death at not resulting i	of):  a 3 Ectopic pre 5 Other (spe on the underlying calculation):  utpatient 3 DO. Time of linjury M	26. Place of C  Other: 4 \( \text{Nursing} \)  1 \( \text{Yes} \)  26. Place of C  A \( \text{Other: 4} \( \text{Nursing} \)  1 \( \text{Yes} \)  2 \( \text{No.} \)	24a. Was autor performed autor performed by the second of	obacco us  Yes 2 [ an an an an an an an an an an an an an	Month  se contribute to the No 3 Prob  24b. Were auto prior to cordeath? 1 Yes	Day Ye ne cause of dea pably 4-Un psy findings av mpletion of cau 2-No
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MAR 2 5 2005

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			1. Decedent's Name (First, Middle, L	ast)							2. Date of		Day	Vana	3. Time of I	
	Physici /Medic		Elsie P. Harm	on							March	6,	2005	Year	7:12 I	Рм
	Examir		4a. Facility Name (If not institution, g	ve street and nu	umber)		4b. C	ty, Town, c	r Location	of Death			4c. County	of Deeth	-	
			Solomons Nursing	Center	•		So]	omons	5_				Calve	ert		
	Funeral		5. Social Security Number 6.	Sex	7. Age	(In yrs. last birth	Mont	der 1 Year ns Days	If Under Hours	24 Hrs. Min.	8. Date of (Month,	Birth Day, Y	ear)	9. Birthp Cour	place (State or	Foreign
ı.	Director		224-32-4797	1□ M 📆 🗆 F	75	Υ	rs.				Sept.	8,	<sup>ear)</sup> 1929	Virg	jínia	
	and *		Usual Residence of Decedent  10a. State 10b. County			10c. City, Town	or Location							1	0d. Inside City	v Limits
	laryli sho	ō				-									1 🗆 Yes	
	28a-	ect	Maryland Calvert  10e. Street and Number		l	Prince I		LCK Zip Code				100	. Citizen of	Mhat Cour		Χ
	with of	ä	71 Armory Road					0678							-	
	death with the Maryland rms 23a or 28a-f show firust be notified at	era	11. Marital Status	12. Was Dec	edent F	ver in U.S.			lispanic Or	igin? (Sp	ecify Yes or		ited		an Indian,	
350	J within 72 hours after death with the Manylar Jiene. r then "nature", or Items 23a or 28a-1 show The Modical Examinative notified at	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed F 1 Tes If Yes, G Year or I	orces? 2 <b>X</b> N ive			pecify Cub 2 <b>X</b> No			ecify Yes or Rican, etc.)			ck, White,		
ž	2 hou	ed	15. Decedent's	Education		16a. 0	Decedent's U	sual Occur	pation			16	b. Kind of B	usiness/Inc	dustry	
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and		Be C	17. Father's Name (First, Middle, La.	rt)					18. Mothe	er's Nam	e (First, Midd					
<u>a</u>	D 6 6 5	0	A. Horton Pruitt						Lula	Eli	zabeth	As	hby			
Mary	S D E E		19a. Informant's Name/Relationship				-				al Route Nun					
	1 and 2 Health a em 27 is		Donald D. Harmon	, Sr. (H	łusb	and) P.C	.Box	1405,	Prin	ce F	rederi	ck,	Mary	land	20678	
e G	s 1 and of Healt item 2: r other t		20a. Method of Disposition			20b. Place of I	Disposition (i	vame of or other pla	ce)		Date	20	c. Location -	City or To	own, State	
Ĕ	Page hent int: if		M□ Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec	⊔Hemoval from ify)	State	MD Vet	-		· ·	3/11	/05	Ch	elten	ham,	Maryla	nd
Baltimore,	permit. Pages Department of I Importent: If ite any injury or of		21. Signature of Funeral Service Lic	nsee		,			ss of Facili	y Ra	usch F				P.A. 4	
n	8 9 E 8 8		John DJ	t			Broom	s Is	1. Rd	., P	ort Re	pub	lic, i	Maryl	and 20	676
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplic Flons that	caused each lin	the death. Do no	ot enter the n	ode of dyir	ng, such as	cardiac	or respiratory	arrest			Approximate Interval Betw	
	Physician	V 1	Immediate Cause (Final disease or condition	,		Soize	ne		Dis.						Onset and De	
	/Medical		resulting in death)	a Due to	(or as a	consequence of	):		<u> </u>						1	
	Examiner		Sequentially list conditions	b											0	
-	₽ ≓	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		(or as a	consequence of	):									
	icate be executed physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c												
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5	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□ Preg 9□ Unkr		time of death	5 Other	(ѕреспу)				-				
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	ding After fune	lon	1 latural 5 Pending	(Mor	nth, Day	Year) Zob. Inj	ury M	Wor	rk? Yes 2□		200. Describ	OTIOW	injury occurr	ed		
UNISION	deat deat ctor: / the	ica	3 Suicide 6 Could not	be as Black	e of Iniu	ry - At home, farr				140	28f Location	/Stree	at and Numb	er or Rum	I Route Numbe	197
2	lor A after Dire	Certification:	4 Homicide determine	build	ding, etc.	(Specify)	ii, stieet, iac	ory, ornice			City or T			or or rigra.	T T TOURS TRUMBE	01,
	To the Hospitel or Attending Physicien: white 24 hours after death To the Funerel Director: After this certifica completely filled in by the funeral director,		29a. Certifier 1 Certifying I	hysician: To th	e hest o	f my knowledge,	death occur	ad at the fir	me date an	d place	and due to th	0.02110	o(s) and ma	nner as et	atad	
	24 h 24 h Fur etely	Medical	(Check only 2 Medical Extended)	miner: On the t	pasis of	examination and	or investigat	on, in my o	pinion, dea	th occurr	ed at the time	e, date	and place,	and due to	the cause(s)	
	o thin	Me	29b. Signature and title of certifier		M	D		29c. Licens	e number			29d.	Date signe	i (Month, L	Day, Year)	
	F \$ F 0		ATmer	-2:	- 4	Phi	25.	DI	94	27	7	Ma	rch 7	200	5	
			30. Name and address of person wh	completed car	se of do	ath (Item 22a)	vne Prist\	- 1	1 1			1.101		, 200		
	8		Anwar T. Munshi					Suit	e 303	. Pr	ince F	red	erick	MD	20678	
	Sta	te	31. Date filed (Month, Day, Year)			r's Signature	1.4.7	2410	2 303	,				<u> </u>		
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DHI	MH 17 Rev 1/2	001	MAR 0 9 2005	Menger .	. 1	A Specie	25									
						ORIG	INAL									

		•	, FOI	artment of Health and Mental Hygie rtificate of Death	ene . No. 2005 10001					
	Physici /Medic	al	1. Decedent's Name (First, Middle, Last) Estella Beatrix Harris	2. Date of Death Month March  4b. City, Town, or Location of Death	Day Year 3. Time of Death 1. Ac. County of De					
)	Examin Funeral	er	4a. Facility Name (If not institution, give street and number)  5501 Cresent Ave.  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Lanham	Prince George's					
	Director		213-66-2789         1 □ M 2√√ F         52 Yrs.           Usual Residence of Decedent         10a. State         10b. County         10c. City, Town or L	Oct. 19,	1952 Wash., DC					
d 21215-0036	the Maryla r 28s-f sho	Director	Maryland Prince George's	Lanham	1 ☐Yes 2 ☐ No  I. Citizen of What Country?					
	n 72 hours after death with the Marylan "natural", or tlems 23s or 28s-1 show wiral Escriber man be militied at	Funeral D	5501 Cresent Ave.  11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 □ Yes 2 No	Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	United States  14. Race - American Indian, Black, White et can					
21215-0036	72 hours af 'natural', or ulcal Exem	þ	3 Widowed 4 Divorced Yes, Give Year or Dates:  15, Decedent's Education 16a. Dec	kind of work done during most of working	Specify: American  b. Kind of Business/Industry					
וברב מו	s 1 and 2 should be filed within 72 ho f Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, Its M. Jical	Be Completed	Elementary/Secondary (0-12) College (1-4or 5+) 1  17. Father's Name (First, Middle, Last)	Postal Employee  18. Mother's Name (First, Middle, Ma	Government iden Sumame)					
Maryland	2 should be and Mental is marked o	ToB		ing Address (Street and Number or Rural Route Number, C						
ď.	Pages 1 and 3 nent of Health ent: If Item 27 ury or other tr		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ Removal from State  20b. Place of Disposition cemetery, cre	matory or other placedark	c. Location - City or Town, State					
	permit. Pages Department of Importent: If It any Injury or o				Laurel, MD uneral Home ash., DC 20019					
) P	Physician		23a. Part   Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease of condition Liver Failure							
	/Medical Examiner	ler	resulting in death)  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	creatic Cancer						
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Records, I	The law requires that the the bas been signed by the bage 2 should be detache	by	Part II. Other significant conditions contributing to death but not resulting in the	1 ☐ Yes	co use contribute to the cause of death?  2 \[ \text{No} \] No \[ 3 \[ \text{Probably} \] 4 \[ \frac{\text{MUnknown}}{\text{Unknown}} \]					
		<b>Completed</b>	25. Was case referred to medical	24a. Was an autopsy performe 1 ☐ Yes 2 ☐ 26. Place of Death (Check only one)						
ivision	Phys this ral dii	lon; To Be	examiner? 1	ent 3 DOA Other: 4 Nursing Home 5 X Residence of 28c. Injury at Work?						
	ten deal tor:	Certification;	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)		et and Number or Rural Route Number, State)					
	To the Hospitel or All within 24 hours effer of To the Funerel Directompletely filled in by	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occurred at the time, date	se(s) and manner as stated. e and place, and due to the cause(s)  I. Date signed (Month, Day, Year)					
	To the comple	4	29b. Signature and title of certifier  All Market Signature and title of certifier  30. Name and address of person who completed cause of death (Item 23a) (Type	D0060050	March 9, 2005					
_	Sta	ite	Mahrukh Hussain, M.D. 1221 Merca  31. Date filed (Month, Day, Year)  32. Registrar's Signature	antile Lane, Largo, MD 207	74					
DIA	Regist		MAR 1 1 2005 Seem & Sp	ME						

			1 - For State Registrar		arylan		artment of F		nd Mental F	lygien Reg. No	- 000	10285
н	Physici	an	Decedent's Name (First, Middle, Last						2. Date of Month	Da	y Year	3. Time of Death
	/Media	cal	Bennie Jean  4a. Facility Name (If not institution, give	Hayes			45 City T	-1	March		2005	9:41P M
	Examir	ier	3704 Walters La				4b. City, Town, o	tvill		40	P.G.	ith
	Funeral		Social Security Number 6. Se	x 7. Ag	je (In yrs.	last birthday)	If Under 1 Year	If Under 24	Hrs. 8 Date of	Birth	9. Bir	rthplace (State or Foreign
	Director		230-00-0301	]M 2 <b>∏</b> F	6	66 Yrs.	Months Days	Hours	Min. (Month, May 1	Day, Year, 7, 1	C	ountry) est VA
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
	Maryl f sho	tor	Md. P.G.			restv						1 XYes 2 □ No
	n the	Director	10e. Street and Number				10f. Zip Code			10g. Ci	tizen of What Co	ountry?
	th wit		3704 Walters La	ne			20	747		Uni	ted St	ates
	tame	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		.S. 13. \	Vas Decedent of H f Yes, specify Cuba	ispanic Origin an, Mexican, P	? (Specify Yes or uerto Rican, etc.)	No-	14. Race - Ame Black, Whi	
36	rs afte	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ If Yes, Give Year or Dates:	No		I ☐ Yes 21X No				Specify:	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Itame 23a or 28e-f show fre M. cical Exz. citrar cust be notified at	ted	15. Decedent's Edu	cation		16a. Deced	lent's Usual Occup	ation		16b. K	B1	.ack
215	thin 7 e. an "n	Completed	(Specify only highest grad Elementary/Secondary (0·12)	e completed) College (1-4or	5+)	(Give life. L	kind of work done of OO NOT use retired	during most of 1)	working			· · · · · · · · · · · · · · · · · · ·
7	ygien ygien nar th		12			Key	board O	perat	or		P.O.	
Maryland	ntal H ed otl	Be	17. Father's Name (First, Middle, Last)						Name (First, Mide		Sumame)	
Ž	should nd Me mark matic	ဥ	Mexico Staples  19a. Informant's Name/Relationship (7)			19h Mailin	a Address (Street	Chan		rris	T Citate	T- 0-4-1
S	nd 2 saith ar 27 is r treu		Fredrick Hayes/			3704 Fore	g Address <i>(Street a</i> Walter stville	s Lane	e 20747	inber, City (	or rown, state, z	zip Code)
Ze,	es 1 a of Hea litern		20a. Method of Disposition		20b. P	lace of Disposemetery, cren	sition (Name of natory or other place	a)	Date	20c. Le	ocation - City or	Town, State
Ĕ	Page ment ent: If ury o		1 X Burial 2 ☐ Cremation 3 ☐ F  '4 ☐ Donation 5 ☐ Other (Specify)	femoval from State			ill Cem		11/05	Su	itland	, Md.
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or itame 23a or 28e-f show any injury or other treumatic event, the Modest Exacilinating at Once.		21. Signature of Funeral Service Licens	99		22	. Name and Addres	ss of Facility	Hodges	& E	dwards	F.H.
	20 = a 0		Janice Ed	ward	2	39	10 Silv	er Hi	ll Rd.,	Sui	tland,	Md.20746
			snock, or heart failure. List only one cause on each line.  Interval Between Onsel and Death Onsel and Death									
	Physician /Medical		disease or condition resulting in death)	Due to (or as			Ovari	an	Can	cer		6 yrs-
	Examiner		Sequentially list conditions	),								975
	sit ad	Examiner	Sequentially list conditions, if any, leading to immediate oause. Early Industrying Cause (Disease or injury	Due to (or as	a consequ	uence of):						
	xecute and II-tran	xam	that initiated events resulting in death) Last  Due to (or as a consequence of);									
8/60	ficate be executed physicien and is the burial-transit	dlcalE	d									
9	tificat ng phy as the	Medic										
Box	leath certific attending p	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome 1□Live birth			Ectopic pregnancy				23d. Date of deli	
O.	law requires that the death certific as been signed by the attending p 2 should be detached for use as	Physiclan/Me	1 Yes 2 No	4☐ Pregnant at 9☐ Unknown			Other (specify)				Month	Day Year
٦.	es that the de igned by the be detached	Ph	Part II. Other significant conditions cor	atributing to death b	ut not resu	alting in the un	derlying cause give	on in Part I.	23e. Dio	d tobacco u	ise contribute to	the cause of death?
Kecords,	quires n sign	ed by	Recurren			ice 5						obably 4 Unknown
S	aw requ s been 2 shouk	Completed							24a. W	ıs an	24b. Were au	Itopsy findings available
	The lav ate has page 2	Com							per	lopsy rformed? 2X No	prior to death?	completion of cause of
Vital	sicien: The certificate hi	Be (	25. Was case referred to medical examiner?					26. Place of 0	Death (Check only		1,103	223110
	Phyei this c	2	1 ☐ Yes 2 No F	ospital: 1  Inpatie		ER/Outpatient		4   Nursin	g Home 5X Re			cify)
0	ding h. After funer	tlon	1 Natural 5 Pending 2 Accident Investigation	(Month, Day	Year)	28b. Time of Injury	28c. Injury Work	at ? ∕es 2 □ No	28d. Describe	e how injur	y occurred	
Division of	Attendi sr death. actor: A by the fu	ifica	3 Suicide 6 Could not be determined	28e. Place of Inju	ıry - At hoi	me, farm, stre			28f. Location	(Street and	d Number or Ru	ıral Route Number,
5	rs after all Dir	Certification:	4 - Horricida	building, etc	с. (Ѕресну,	)			City or T	own, State,	)	
	To the Hospitel or Attending Physicien: within 24 hours after deals.  To the Funarsi Director: After this certific completely filled in by the funeral director,	edical	29a. Certifier (Check only one)  1 Certifying Phys 2 Medical Examin	ician: To the best of	of my knov examinati	viedge, death	occurred at the tim	e, date and pla	ace, and due to th	e cause(s)	and manner as	stated.
	thin 2 the or the	Med	29b. Signature and title of certifier	and manner sta	ited.		29c. License	(T)	C)			
	F3F8		wilded	Andres					21		e signed <i>(Month</i> なんしい	08, 2005
)	(5)	1	30. Name and address of person who co	mpleted cause of d	eath (Item	3a) (Type, F	rint) L90	10 G	POYCE	Q.	· D	C 20202
_			mildred Rodnie	nez W	atte.	Rec	d Arm	y Med	ical o	しい	WEST	1
	Sta	-	mildred Rodn's 31. Date filed (Month, Day, Year) MAR.: 1 1 2005	Registra	ar's Signati	ure		,	_			
	Registra	2T	TRIAIN 1 LUTUU		1							

			Flease Type of Frint in Black inc		-		
	7		1 - Stata Registrar aaco health dept. cmh Cer	tificate of Death	Reg	. No. 2005	10286
	Physici	an	Decedent's Name (First, Middle, Last)     ELIZABETH MALLETTE HOOVER		2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examin	al	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	IARCH 05	4c. County of Death	3:30 P M
j.	Examilia	ĆΙ	HERITAGE HARBOUR HEALTH AND REHAB.	ANNAPOLIS		ANNE ARUNDE	EL
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Months Days Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Birthpla Countr	ice (State or Foreign
	Director		264 12 9999 88 Yrs. Usual Residence of Decedent		AUG. 16,	1916   FLORI	LDA
	arylane show	_	10a. State 10b. County 10c. City, Town or Loc	cation		10	d. Inside City Limits  1 Yes 2 No
	the Mi	Directo	MARYLAND ANNE ARUNDEL ANNAPOLIS  10e. Street and Number	10f. Zip Code	100	. Citizen of What Countr	
	ter death with the Marylar Items 23s or 28s-f show Items 19st by routilled at	I Dir	434 CRANES ROOST CT.	21401		UNITED STATE	
	ems 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent	Vas Decedent of Hispanic Origin? (Spec f Yes, specify Cuban, Mexican, Puerto R	cify Yes or No- lican, etc.)	14. Race - America Black, White, et	
30	hours after death with the Maryland .ural; or Items 23s or 28s-f show al Exattems traust by restilled at	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 M No If Yes, Give 1 3 ☑ Widowed 4 ☐ Divorced Year or Dates:	I ☐ Yes 2 📉 No Specify:		Specify: WHIT	Œ
215-0036		ted	15 Decedent's Education 16a Deced	lent's Usual Occupation	16	b. Kind of Business/Indu	ıstry
2	within 72 ene. than "nei he Medic	Completed	Elementary/Secondary (0-12)   College (1-4or 5+)	kind of work done during most of workin OO NOT use retired)		HOVE	
N O	filed Hygi other		8 O HOM  17. Father's Name (First, Middle, Last)	EMAKER 18. Mother's Name	(First, Middle, Ma	HOME iden Sumame)	
land	uld be Aental irked c	To Be	WILLIAM LEWIS MALLETTE	ELOISE B	BROOKS		
Mary	s 1 and 2 should f Health and Men item 27 is marke other traumatic	·	1 1 21 1	g Address (Street and Number or Rural RANES ROOST CT. A		City or Town, State, Zip C S.MD. 21401	Code)
	1 and Health Iem 27 other t		20a Method of Disposition 20b. Place of Dispos	sition (Name of Da		c. Location - City or Tow	m, State
ē	Page: ent o nt: if		1 ☐ Burial 2 ☐ Cremation 3 ☑ Removal from State  '4 ☐ Donation 5 ☐ Other (Specify)  HILLCREST	MEM. PARK 03-11-	-05 WE	EST PALM BEA	CH,FLA.
Baltimore,	permit. Departm Importa any inju			. Name and Address of Facility $GEOR$			
	ಕ್ರಕ್ಷ ನ		23a, Part1, Enter the disease, or complications that caused the death. Do not enter	973 SOLOMONS ISLAN			Approximate
	Dhyeisian		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final	A	~~~/		nterval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)  a	West of the	1, -7		
	Examiner	_	Sequentially list conditions, b. Due to (2000 2000 2000 2000 2000 2000 2000 20	voseps-			
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	i Renal Pruline			
ລົ	ate be executed nysician and he burial-transit		that initiated events resulting in death) Last	ared events c.			
09/89	ate be shysicia the bu	dical	d				
	The law requires that the death certificate the been signed by the attending phy age 2 should be detached for use as the	by Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery	(
. Box	death le atter	siciar	in the past 12-months?	Ectopic pregnancy Other (specify)			ay Year
J.	that the de led by the a	Phys	9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the un	nderwing cause given in Part I	23a Did tobas	cco use contribute to the	cause of death?
ďs,	w requires to been signer should be co		Takin. Silist Significant containing to death eacher season, and the	art ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.			
ecords,	aw req s beer 2 shou	Completed			24a. Was an autopsy	24b. Were autops	sy findings available pletion of cause of
r		Som			performe	d?   death?	
VItal	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?  Hospital:	26. Place of Death			
Ö	Phys this ral di	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of	28c. Injury at 28	e 5 ∐ Residend 8d. Describe how	e 6 ☐Other (Specify) injury occurred	
ion	Attending Fir death. ector: After by the funera	atlo	1 X Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No			
UIVISION	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)	et, factory, office 2	8f. Location (Stree City or Town, S	et and Number or Rural I State)	Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		29a. Certifier 1X Certifying Physician: To the best of my knowledge, death				
	To the Ho within 24 To the Fu	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or inv and manner stated.	29c. License number		and place, and due to the and place, and due to the and place, and due to the and all the and all the and all the and place, and due to the and due to the and due	
							) i
	,		30 Name and address of person who completed cause of death (Item 23a) (Type, F	Print)	2	ulle me)	21225/
	82		31. Date filed (Month, Day, Year) 32. Agistrar's Signature	egstess (	amgr	ulle mi)	XILAS
1	Sta Registr		MAR 0 9 2005	model		·	

			For State Registrar	State of Maryland / I	Department of F Certificate of			eg. No. 200	10287		
	Physici /Medi Examir	cal	1. Decedent's Name (First, Middle, Last, Sarah E  4a. Fecility Name (If not institution, give Vindabona Nurs	E. Hightman		or Location of Death	Feb.	24, 2005 4c. County of Dea Freder			
	Funeral Director		5. Social Security Number 155-20-3311 6. Security Number 15 5-20-3311				8. Date of Birth (Month, Day Mar		thplace (State or Foreign ounto)		
Maryland 21215-0036	he Maryland 88-1 ahow cultied at	Director	ctor	Usual Residence of Decedent  10a. State 10b. County Frede  MD Frede	erick 10c. City, Tow	m or Location Middletowr	1	1	0g. Citizen of What C	10d. Inside City Limits  **T Yes 2 No	
	deeth with ima 23e or in	Funeral Dir	11. Maritat Status	323 S. Churc  12. Was Decedent Ever in U.S. Armed Forces?	h St.	21769		USA  14. Race - Am-	encan Indian,		
	72 hours after deeth with the Maryland natural', or itema 23e or 28a-f ahow dical Examiner must be notified at	ed by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1 ☐ Yes 2 🕱 No	Specify:			Vhite		
	nit. Peges 1 and 2 should be filed within 72 hours after deeth with the Marylan ertment of Health and Mental Hygiene ortant: if item 27 is marked other than "natural", or itema 23e or 28a-f ahow injury or other treumatic avant, the Modical Examiner must be notified at its 18.	Completed by	(Specify only highest grad	e completed)  College (1-4or 5+)	(Give kind of work done life. DO NOT use retired ashier	during most of won d)	king	public education	·		
ryland	hould be file d Mental Hy narked oth natic avant	To Be	17. Father's Name (First, Middle, Last)  Claude B.  19a. Informant's Name/Relationship (T)		o. Mailing Address (Street	Erma	House		Zin Code)		
	s 1 and 2 si f Health and itam 27 is r		Daryl Hightman	(Son) 3	940 Valley of Disposition (Name of lary, crematory or other place)	y View R	d., Mi		MD 21769		
Baltimore,	permit. Pages Depertment of Important: If it eny injury or o		1 分Burial 2 □ Cremation 3 □ F  '4 □ Donation 5 □ Other (Specify)  2 □ Scotture of Full and Se ver Lio hs	Luth	eran cemet Domaldoor	sery 2/2	son Fu	Middletov	ne		
	Physician /Medical		23a Part 1. Enter the disease, or complished, or heart failure. List only of Immediate Cause (Finat disease or condition resulting in death)	aspiration	not enter the mode of dyir			etown, MI est,	Approximate Interval Between Onset and Death  days		
	ysicien and eburial-transit	nysician/Medical Examiner	Sequentially list conditions, if any, leading to immediate rause First Industrying Cause (Disease or Injury	Due to (or as a consequence  Cerebrovasc  Due to (or as a consequence  Due to (or as a consequence	ular accid	lents			7 yrs.		
.O. Box 68	death certif e attending d for use as		nysician/Me	Physician/Me	hysiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes ★★No 9 □ Unknown	23c. If yes, outcome of pregnancy  1	n 3 □Ectopic pregnancy 5 □ Other (specify) _	у		23d. Date of de Month
σ	wrequires that the been signed by the should be detache	þ	Part II. Dther significant conditions co	I Harris Aven - Aven - Aven - Aven	in the underlying cause giv	ven in Part I.		pacco use contribute to	o the cause of death?		
Vital Records	The law ate has b page 2 s	Completed	renal fail	ure, chronic			24a. Was a autops perform	y prior to death?	utopsy findings available completion of cause of		
/ita	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:	ottostinat 30 DOA Ott	ac.	th (Check only on				
of	Phys this al dir	tlon; To	1 Yes 2 No  27. Manner of Death  XXNatural 5 Pending 2 Accident investigation	28a. Date of Injury 28b.	Time of 28c. Injury Wor	y at		nce 6 □Other (Spe w injury occurred	ecify)		
Division	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, for building, etc. (Specify)			City or Towr				
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	(Check only 2 Medical Exami	sician: To the best of my knowledg ner: On the basis of examination a and manner stated.	nd/or investigation, in my d	ppinion, death occui	rred at the time, di	ause(s) and manner a ate and place, and du	e to the cause(s)		
	w to	-	29b. Signature and title of certifier  30. Name and address of person who certifier	ompleted cause of death (Item 23s)		0488	2	3/8/05	, saj, 1501)		
	St	ate	James L. Roess 31. Date filed (Month Pay, Year) 20			iddletow	n, MD 2	21769			
	Regist		MINI/ T T C	The state of the s	The state of the s						

			_ FOF	partment of Health and Me ertificate of Death	ntal Hygien Rag. N	2005	10288
	Physici	an	1. Decedent's Name (First, Middle, Last)			0 2005	3. Time of Death 10:05 AM
	/Medio Examin	_	Ray Andrew Hughes 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	10:03 A
			Union Hospital	Elkton		Cecil	
	Funeral		5. Social Security Number 6. Sex 1 TMM 2 TF 7. Age (In yrs. last birthda) 65 Yrs.	Months Days Hours Min.	. Date of Birth (Month, Day, Yea	9. Birthpla Count 0, 1940	
	Director		Usual Residence of Decedent		bruary 1		VA
	show	_	10a. State 10b. County 10c. City, Town or I	Location		10	ld. Inside City Limits 1 ☐ Yes 2 🛣 No
	vith the Maryla or 28e-f shor the notified at	Director	MD Cecil Elkton  10e. Street and Number	10f. Zip Code	10g. C	Citizen of What Count	
	3a or		77 Fair Hill Drive	21921		SA	.,-
	ems 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13 Armed Forces?	. Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto Richard Control of the Control		14. Race - America Black, White, e	
36	filed within 72 hours after death with the Maryland Hygiene. nther than "netural", or Items 23a or 28e-f show ent, the Medical Examiliar must be notified at	by Fu	1 Never Married 2 X Married 1 X es 2 No If Yes, Give 3 Widowed 4 Divorced Year or Dates:	1 ☐ Yes 2 ☐ No Specify:	,	Specify: White	
21215-0036	2 hours		15. Decedent's Education 16a. Dec	edent's Usual Occupation	16b.	Kind of Business/Inde	
215	thin 72 l e. an "net Medica	Completed	Elementary/Secondary (0-12) College (1-40r 5+)	e kind of work done during most of working DO NDT use retired)			
	e filed within the hill Hygiene. other then yent, the M			Estate Investor  18. Mother's Name (/		Real Estat	te
Maryland	be d la la la la la la la la la la la la la	o Be	17. Father's Name (First, Middle, Last)  Earl W. Hughes	Ina B. Be		en sumame/	
ary	d 2 should be th and Mental i? is marked c treumatic eve	F		ling Address (Street and Number or Rural F		y or Town, State, Zip (	Code)
	Health a tem 27 is			Fair Hill Drive, Elk		21921	
3altimore,	Pages 1 and nent of Healt ont: If item 2 ury or other		Medical 5 Determation 3 Determoval from State	position (Name of Pate Place) Date 3-15-	2005	Location - City or Tov	
ij	교론분들 .			Memorial Gardens		erdeen, Mī	
Ba	Depar Depar Impo any ir		The hard of Chardin	111 S. Queen Street,	kisina :	uneral Hon Sun. MD 2	1e, P.A.
			23a. Part1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.				Approximate Interval Between
	Physician		Immediate Jause (Final disease or condition	Infarction			Onset and Death
	/Medical Examiner		resulting in death)  Due (or as a consequence of):				
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying				
48	cuted nd ransit	Examiner	that initiated events c				
	be executed sician and burial-transit		resulting in death) Last Due to (or as a consequence of):				
68760,	icate b physic	dlca	d				
Box (	eath certifica attending ph I for use as th	n/Me	IF FEMALE: 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3	☐Ectopic pregnancy		23d. Date of deliver	•
	e deat the atte	Physician/Medical		Other (specify)		Month (	Day Year
P.0.	res that the de signed by the a i be detached i		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	use contribute to the	a cause of death?
rds	quires n sign ald be	d by			1 🗆 Yes	2 □ No 3 □ Proba	ibiy 4 <b>Q</b> Unknown
000	ie law requir has been si je 2 should l	Completed			24a. Was an autopsy	24b. Were autop	sy findings available ipletion of cause of
E. B.	The I	Com			performed? 1 ☐ Yes 2 ☑ N	death?	
Vita	ysicien: The is certificate hadirector, page	Be	25. Was case referred to medical examiner?  Hospital:	26. Place of Death (			
of	Phys or this oral di	To tr	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at 28	5  Residence d. Describe how inj		
ion	ttending Ph death. ctor: After th y the funeral	atlo	2 Accident investigation	M 1 ☐ Yes 2 ☐ No			
Division of Vital Records,	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office 28	f. Location (Street a City or Town, Sta	and Number or Rural ate)	Route Number,
	spitel		29a. Certifier 1 <b>₹ Certifying Physician:</b> To the best of my knowledge, dea	ath occurred at the time, date and place, and	d due to the cause(	(s) and manner as sta	ited.
	To the Hospitel or A within 24 hours after To the Funeral Direct completely filled in by	edical	(Check only one)  2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occurred			
	To t To I	Σ	29b. Signature and title of certifier	29c. License number		Date signed (Month, D	
	ALLA		20 News and advance of access who accessioned access of death (New 22s) True	D0053309	Mar	rch 11, 2	C0/3
	10,0		30. Name and address of person who completed cause of death (Item 23a) (Typi Teffrey M. Tiongson MD, Un	e. Print) ion Hospital, Elk	ton w	1D 219	<b>ə</b> (
	Sta		31. Date filed (Month, Day, Year) 33 Registrar's Signature	and it			
	Registr	ar	MAR 1 4 2005				

			1 - For Stata Registrar	State of M	arylan		artment of F rtificate of		Mental Hy	/gier Reg. I	2001	5 1	0289
	Physici	an	1. Decedent's Name (First, Middle, Las.	)					2. Date of D Month		Day Yea	r	ime of Death
	Physici /Medi		Phyllis	Maxi			Harshberge		MARCH		2005		:30 A M
	Examir	er	4a. Facility Name (If not institution, give Memorial Hospital			nter	4b. City, Town, o		itn		4c. County of De Allegany		
	Funeral Director		5. Social Security Number 6. Se			ast birthday) Yrs.	If Under 1 Year Months Days			irth	9.8		State or Foreign
	D		Usual Residence of Decedent  10a, State 10b, County		10a Cib	/, Town or Lo	l l					10d Inc	ide City Limits
	faryla shov	ō			Tuc. City								Yes 2 □ No
	the N	rect	MD Allegany  10e. Street and Number			CL	mberland			10g.	Citizen of What (	Country?	
	h with	a Di	1608 Bedford	Street				21502			USA		
36	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene tiem 27 is marked other than "natural", or items 23e or 28e-1 show other treumatic event, the Medical Examinat must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 X If Yes, Give Year or Dates:	•		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🗓 No	lispanic Origin? ( an, Mexican, Pue Specify:	Specify Yes or N rto Rican, etc.)	0-	14. Race - An Black, Wh Specify:		
9	'2 hou	ted	15. Decedent's Ed	ucation		16a. Dece	dent's Usual Occup	pation	orking	16b.	. Kind of Busines		
215	ithin 7 ne. nan "r	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT use retired	d)	· ·				
121	e filed within al Hygiene. I other than '		12 17. Father's Name (First, Middle, Last)	1		Certif	ied Nursin		it ame (First, Middle	a Maid	Nursing I	lome	
and	d be f ental b ced of	o Be	Lawrence	Jesse	M	liller		Nellie				turtz	
Maryland 21215-0036	2 should be n and Mental is marked reumatic ev	2	19a. Informant's Name/Relationship (T	ype, Print)		19b. Mailin	ng Address (Street	and Number or F	Rural Route Numi	ber, Cit	y or Town, State	, Zip Code)	
	and 2 salth a n 27 is		Fred H. Harshberger,	Sr. / husb			Bedford St:	reet, Cumb					
altimore,	ages 1 of He or oth		20a. Method of Disposition 1 X Burial 2 Cremation 3 □	Removal from State		lace of Dispo emetery, crei	osition (Name of matory or other plac	1	Date	20c.	. Location - City of	or Town, Sta	ate
Ē	permit. Page Department Importent: any injury once.		<ul><li>4 □ Donation 5 □ Other (Specify)</li><li>21. Signature Fundral Service License</li></ul>		Suns		orial Park 2. Name and Addre	1	9/2005 dame Famil		mberland,		
Bal	permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other tre once.		21. Signature Functai Service Licens	11		24	404 Decatu			•		,	•
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that cause	the death	. Do not ent	ter the mode of dyir	ng, such as cardia	ac or respiratory	arrest,		Appro	ximate al Between
	Physician		Immediate Cause (Final disease or condition	a MYOCARD		INFARC'	TTON					Onset MINU	and Death
	/Medical Examiner		resulting in death)	Due to (or as			11011						
Ь		ā	Sequentially list conditions,	b. Due to (or as	a eoneuge	ianee of):							<u> </u>
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events										
o,	e exection and an arrial-tr	Еха	resulting in death) Last	Due to (or as	a consequ	ience of):						Ī	
8760,	icate be executed physician and the burial-transit	dical		d									
.O. Box 6	ath certifi ttending or use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal	death 3[	Ectopic pregnancy Other (specify)	/			23d. Date of d Month	elivery Day	Year
₽	that the de led by the a detached f	Phy	Part II. Other significant conditions of	ntributing to death b	out not resu	ulting in the u	nderlying cause giv	ren in Part I.	23e. Did	tobacc	o use contribute	to the caus	e of death?
Records,	tuires than signed and a signed	d by	AORTIC INSUFFICIE	NCY, PARK	CINSON	N"S DI	SEASE		1 🗆	Yes	2 <b>⊠</b> No 3 ☐ F	Probably	4 □Unknown
000		Completed	GENERALIZED ANXIE	TY					24a. Wa	s an	24b. Were	autopsy find	dings available
Ä	9 4 9	om							perf	ormed'	? death?	s 2 N	
Vital	ysiclen: Th is certificate director, pag	Bec	25. Was case referred to medical examiner?				lou		eath (Check only	one)			
of	d is	P.	1 ☐ Yes 2 🔁 No  27. Manner of Death	Hospital: 1 Inpati 28a. Date of Inju		ER/Outpatier	nt 3 DOA Oth	4 🗆 Nursing	Home 5 Res			ecify)	
	ding h. After fune	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Da	y Year)	Injury	War	k?` Yes 2∐No	204. D630100	11041	ijary cocurred		
Division	l or Attending after death, Director: After In by the fune	Certification:	3 Suicide 6 Could not be determined				reet, factory, office		28f. Location City or To		and Number or I	Rural Route	Number,
Ö	itel or A rs after el Direc led in by	Cert	4 I Homodo	building, et	ic. (Specify				Oily or 70				
	To the Hospitel or Attenwithin 24 hours after deat To the Funerel Director: completely filled in by the	ledicai	(Check only 2 Medical Exam	rsician: To the best iner: On the basis o and manner st	f examinat		vestigation, in my o	pinion, death occ		, date a	and place, and du	ue to the ca	
		Σ	29b. Signature and title of certifier	il	aln		29c. Licens				Date signed (Mai		
•	5	1	1 Hma Slian		tooth (harr	-22a\ /T	D463	346	1.000	MAR	CH 7,	200	)5
	714		30. Name and address of person who of DR. HUMA SHAKIL,					G., 625	KENT AVE	. c	UMBERLAI	ND, M	D 21502
	Sta	te	31. Date filed (Month, Day, Year)	7									
	<ul> <li>Registr</li> </ul>	ar	MAR 0 7 20	105 Sec.	75 F S	The state of the s	A CONTRACTOR OF THE PARTY OF TH						

			1 - For State Registrer	ite of Marylan	•	artment of H tificate of I		lental Hygier Reg. 1	4000	10290
	Physici	 an	Decedent's Name (First, Middle, Last)     Rosanne	Louise	Har	VAV		2. Date of Death Month March 10	Day Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give street		nar		r Location of Death		2005 4c. County of Death	00:50AM M
	Examin	er	Memorial Hospital	ard Hambory		Cumberla			Allegany	
	Funeral Director		5. Social Security Number 6. Sex 1 5 8 - 3 2 - 9 9 4 0	7. Age (In yrs. )	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea 01/15/194	ar) Cour	place (State or Foreign htty) Jersey
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. City	y, Town or Lo	cation			1	0d. Inside City Limits
	Mary a-f sh	tor	MD Allegany			Rawlings				1 ☐ Yes 2 🔯 No
	3c or 28	al Direc	10e. Street and Number 16010 Maple Lane			10f. Zip Code 2155	57	10g. (	Citizen of What Cour USA	ntry?
36	be filed within 72 hours after death with the Maryland ital Hygiene. In other than "natural", or Itame 23c or 28e-f show event, if a Modical Exaction of the Locality of the Modical Exaction of the Locality of the Modical Exaction of the Locality of the Modical Exaction of the Locality of the Modical Exaction of the Locality of the Modical Exaction of the Locality of the Modical Exaction of the Locality of the Modical Exaction of the Locality	by Funeral Director	1 Never Married 2 Married 1 I	us Decedent Ever in U. ned Forces? Yes 2 X No 'es, Give ar or Dates:		Vas Decedent of H f Yes, specify Cuba I ☐ Yes 2 ☒ No	ispanic Origin? (Spe tn, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify:	
9	2 hour		15. Decedent's Education		16a. Deced	lent's Usual Occup	ation	16b.	Kind of Business/In	
215	ithin 7. ne. nan "n	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working) (Give kind of work done during most of working) (Iife. DO NOT use retired)  12  Registered Nurse								
d 21	e filed within at Hygiene. other then vent, It e Ma		12 17. Father's Name (First, Middle, Last)	3		Kegiste		(First, Middle, Maid	Hospital	
lan	ild be lental lental l	To Be		hias	Jenr	ings	Virgin		L.	Kutz
Maryland 21215-0036	nd 2 should be alth and Mental 27 is markad r traumatic ev		19a. Informant's Name/Relationship (Type, Pr Victor O. Harvey / h			-	and Number or Rura Lane, Raw	l Route Number, City lings, MD	y or Town, State, Zip 21557	Code)
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If itam 27 is markad any injury or othar traumatic e pnce.		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □ Remove 4 □ Donation 5 □ Other (Specify)	.,	emetery, cren	sition <i>(Name of</i> natory or other place nd Cremat	e) 1		Location - City or To umberland	
Balti	permit. Departm Importa any inju		21. Signature of Fylheral Service Licensee	kare	22	Name and Addres		ams Famil	,	Home, P.A. 21502
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau	s that caused the death	. Do not ente	er the mode of dyin	g, such as cardiac o	r respiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical			ltiple tra		th medica	1 complic	ations		1½ months
	Examiner			Due to (or as a consequ	uence of):					
	7 F	ner	cause. Enter Underlying	Due to (or as a consequ	uence of):					
	ecute and I-trans	Examiner	Cause (Disease or injury that initiated events c.	Due to (or as a consequ	ience of):					
8760,	ficate be executed physician and s the burial-transit	dlcal E	L <sub>d</sub>							
9	tificate ng phy as the	0	VI							
.O. Box	es that the death certifics igned by the attending pt be detached for use as t	Physician/M	in the past 12 months?	es, outcome of pregna ]Live birth 2	death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	nry Day Year
0		by	Part II. Other significant conditions contributi	ng to death but not resu	ulting in the ur	iderlying cause give	en in Part I.	23e. Did tobacci	ouse contribute to the	1
Records,	e law has b	Completed						24a. Was an autopsy performed?	prior to cor	psy findings available inpletion of cause of
Vital	ician: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?			01	26. Place of Death	(Check only one)	<del></del>	
of/	Phys this al dir	.T	Yes 2 ☐ No Hospita 27. Manner of Death 28a	E Inpatient 2□I Date of Injury	ER/Outpatien	28c. Injury		ne 5 Residence 28d. Describe how in		)
	Attending r death. actor: After by the funer	tlon	1 Natural 5 Pending	(Month, Day Year)	Injury 15:56	Work	(?	automobil		
Division	a Hospital or Attendi 24 hours after death a Funeral Diractor; 4 etely filled in by the f	Certification:	3 Suicide 6 Could not be 286	. Place of Injury - At ho	me, farm, stre	eet, factory, office		28f Location (Street	and Number or Rum	l Route Number
Ō	Hospital or		<u> </u>	building, etc. (Specify Highway					ale MD 215	
	To the Hospital or Attentwithin 24 hours after deatl To the Funeral Director:	edical	29a. Certifier  (Check only one)  1 Certifying Physicien: 2 Medicel Exeminer: 0 ar							
	To tha within 2. To tha complet	Me	29b. Signature and title of Pertifier	1)		29c. License			Date signed (Month,	
)	2		Xail	him		D091	57	Mar	ch 10 2005	5
	DAS.		30. Name and address of person who complete				harland M	d 21502		
	Sta	te	Paul Snow, M.D. Dpty 31. Date filed (Month, Day, Year).	32. Figistrar's Signal	ture	u st cum	berland M	u 21302		
	Registr	ar	MAR 1 1 2005	Lineva	13. 16	raise				

Amended #19b, nls, Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 03/11/05, Allegany Co. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year 10:35 PM **Physician** 05 SHIRLEY ANN HERSH /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Heart Alleganu Sacred Hospital land umber If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Min 1 ☐ M 2 🕱 F Months Davs Hours Director 212-24-2319 74 1930 MARYLAND Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County Item 27 is marked other than "natural", or items 23s or 28e-f show other traumatic event, the Madical Examiner must be notified at 1 Yes X No Director CRESAPTOWN MD ALLEGANY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13014 6th. AVENUE 21502 U.S.A. Completed by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 20 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE 3X Widowed 4 ☐ Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "r any injury or other traumatic event, the Mad ADGS. Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER HOME 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JOSEPH SMITH ODESSA FARRIS ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Stoneybrook 19a. Informant's Name/Relationship (Type, Print) KATHIE SMITH / DAUGHTER 14300 STONEYBRROK-FARM LANE, CRESAPTOWN, MD 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State HILLCREST BURIAL PARK 03/12/2005 CUMBERLAND, \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility UPCHURCH FUNERAL HOME, P.A. 202 GREENE STREET, CUMBERLAND, MD 21502 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cerebrovascular accide 10 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed use as the burial-transit attending physician and Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 25 No 24a. Was an autopsy ZX No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 20XN0 1 Yes 1/XInpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Natural 2 Ccident 1 Yes 2 🗌 No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

 Hospitel or Attending Pt
 24 hours after death.
 Funeral Director: After th To the Hospitel within 24 hours a To the Funeral C 10

MAD

State

29a. Certifier (Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

200 rgetlennaw

e tennawi, mi

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Co

925

2. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

12005

3/10

54 Road, amberland, MD Z1502

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year Mary Elizabeth 2005 /Medical Hesse March 11, 1515 P 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Garrett Memorial Hospital Oakland Garrett 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 03/29/1911 9. Birthplace (State or Foreign Country) Mary land **Funeral** 1 ☐ M 2 🏻 F Director 93 216-18-6227 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If them 27 is marked other then "naturel", or Iteme 23e or 28e-f show any injury or other treumetic event, the Maglicial Franchisco. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No MD Garrett Kitzmiller 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 258 Main Street 21538 USA Funeral Was Decedent Ever in U.S. Amed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify: Completed by 3 N Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Owner Beauty Shop 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) John ဥ Bishop Lectie Rodeman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Hesse / son 9118 Highland Ridge Way, Tampa, FL 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 In Cremation 3 ☐ Removal from State Cumberland Crematory 03/13/2005 \* 4 ☐ Donation 5 ☐ Other (Specify) Cumberland, MD 21. Signature of Funeral Service Licenses Adams Family Funeral Home, 22. Name and Address of Facility 404 Decatur Street, Cumberland, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** <u>Acute Myocardial Infarction</u> week /Medical Due to (or as a consequence of): Examiner Ischemic Cardiomyopathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last > 6 months Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit The law requires that the death certificate be executed Arteriosclerotic Heart Disease years Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medlcal IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death Month Day Year signed by the a' 5 Other (specify) 9 Unknown 9 Dunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ High Blood Pressure een si Completed 2☐No 3☐Probably 4☐Unknown s certificate has a lirector, page 2 s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No or Attending Physicien: Be filled in by the funeral director 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ☐ ER/Outpatient this 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation s after death 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel o within 24 hours aff To the Funerel Di completely filted ir Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3 23 30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print) ZIRS Thomas Johnson, M.D., 311 N. 4th Street, Oakland, MD 21550 31. Date filed (Month, Day, Year)
MAR I 4 Registrar's Signature State 4 2005

DHMH 17 Rev 1/2001

Registrar

		1	For State Registrar	State of M	larylan		artment of F		ind Me		iene g. No. 00	5	10293
	Physici	an	1. Decedent's Name (First, Middle, Cypress Hall						2	2. Date of Dear Month	Day	Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution,		)		4b. City, Town, o	r Location of	f Death	03	08 200 4c. County		0029am
1	EXGINIII	ići	Suburban				Beth	esda			Mont	gom	ery
	Funeral Director				ge (In yrs. 70	last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	B. Date of Birth (Month, Day,		Cour	place (State or Foreign atry) abama
	D		Usual Residence of Decedent							07/12	/ 34		
	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-1 show the Madical Examinar must be notified at	'n	DC None			y, Town or Lo ashind						1	0d. Inside City Limits 1 ☑Yes 2 ☐ No
	the M	Funerai Director	None None None		110		10f. Zip Code			1	0g. Citizen of W	hat Cour	ntry?
	3a or	i Di	217 Webster	Street N	V		200	011			USA		,
	ems 2	ner	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U.	S. 13. \	Was Decedent of H	lispanic Orig an, Mexican,	in? (Spec	ify Yes or No- ican, etc.)		- Americ	ean Indian,
36	s after , or ite	by Fu	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ ② Divorced		954-5	57	_		,	,	Specify:		
9	2 hour	ed b	15. Decedent	s Education		16a. Deced	lent's Usual Occup				16b. Kind of Bu		
21215-0036	thin 73	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-4or	5+)	life. I	kind of work done OO NOT use retired	d) _	of working	7	Posta	1 Se	rvice
121	led wi lygien her th	Con	17. Father's Name (First, Middle, L	3		Sug	pervisor		r'a Nama (	(First Middle )	Maiden Sumame		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Importants if item 27 is marked other than "natural", or Items 23a or 28a-1 show among injury pro-other traumatic avant, the Medical Examinating the notified at once.	To Be	Cypress Hall	·							ackson	*/	
ary	shou and M s mar	-	19a. Informant's Name/Relationsh			19b. Mailin	g Address (Street	and Number	r or Rural	Route Number	, City or Town, S	State, Zip	Code)
Σ,	and 2 ealth a n 27 i	P	Geraldine Por	ctis Sist	_		Webster	st,					
ore	ges 1 t of Hi if itar		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □Removal from State	, c	emetery, cren	sition (Name of natory or other place		Da		20c. Location - (	•	
Baltimore,	artmen ortant:		<ul> <li>4 □ Donation 5 □ Other (Sp</li> <li>21. Signature of Funeral Service L</li> </ul>		Mt		Cemetery Name and Addre		3/14/		Washing		
Ва	Depa Impo any i		Lann	In .	>_	5	Name and Address nead Fund 732 Georg	eral H	NW	& Crema Washin	tion se	rvic	e 11
			23a. Part1. Enter the disease, or o shock, or heart failure. List of	complications that cause only one cause on each	ed the deatl line.	n. Do not ent	er the mode of dyin	ng, such as o	cardiac or	respiratory arr	est,		Approximate Interval Between Onset and Death
	Pnysician		Immediate Cause (Final disease or condition resulting in death)	_ a		2515							Onset and Death
	/Medical Examiner			Due to (or a			ONIA						
		ner	Sequentially list conditions, if any, leading to immediate cause. Entail Underlying Cause (Disease or injury	b. Due to (or a	-								
	ecuted and transi	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c									
8760,	be executed sician and burial-transit		resulting in occurry cast	Due to (or a	s a conseq	uence or):							
9	ificate I g physi as the t	edic		d							1		
Box	eath certific attending pl	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom 1□Live birth			Ectopic pregnancy	y			23d. Date		•
P.O. E	The law requires that the death certificate be executed to has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant 9□Unknown	at time of d		Other (specify)				Mon	uı	Day Year
	res that the de igned by the a be detached t		Part II. Other significant condition			•	, ,	ven in Part I.		23e. Did to	acco use contri	bute to ti	ne cause of death?
g	w requires been sign should be	ed by	PR	OSTATE	CA	NCE	2			1 □ Ye	s 20No	3 🗌 Prob	pably 4 □Unknown
Records,	law requises been	Completed								24a. Was a autops	y pi	ior to co	psy findings available mpletion of cause of
ital B										perform 1 Yes 2	2 No 1	eath?	2€ No
\$	Physiclan: r this certifica ral director,	o Be	25. Was case referred to medical examiner?  1 Yes 2 Ho	Hospital:	ient 2 🗆	ER/Outpatien	t 3 DOA Oth	or		Check only on	e) ince 6 ∏Othe	r /Spacif	iv)
20	Phy this		27. Manner of Death	28a. Date of In		28b. Time of Injury		ry at			w injury occurre		97
Ĵ̈̈̈́	Attanding r death. actor: After by the fune	atio	1 Natural 5 Pending 2 Accident investig 3 Suicide 6 Could n	ation	L) . Gui,	,,		Yes 2□N	No				
Division	l or Attanc after death Diractor: I in by the	Certification;	3 Suicide 6 Could n 4 Homicide determine	ned 288. Place of II	njury - At ho etc. (Specif	ome, farm, str	eet, factory, office		28	If. Location (St. City or Town		r or Rura	il Route Number,
	To the Hospital or At within 24 hours after of To tha Funeral Dirac completely filled in by			Physician: To the best examiner: On the basis									
	To the H within 24 To tha F complete	Medicai	one)  29b. Signature and title of certifier	and manner			29c. Licens				9d. Date signed		
	i 8 1 8 1		200. Oignature and title of certifier	Bes	in	-0	1	057	120		3/8		
•	4		30. Name and address of person v	~γ	death (Iten	1 23a) (Type,	Print)						
			Or Truong Bar	5 NO 138	119 9	execul	ive Parl	K Terr	, Ge	rmantou	on MO	99	794
	Sta Registi		31. Date filed (Month, Day, Year)  MAR 11	2005 ARE	uars signa	ture do	de		,				
2,424													

			1 - For State Registrar	State of Man		artment of H rtificate of L			iene	5 10294
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Dear Month	Day	3. Time of Death
1	/Medi	cal	FREDD 4a. Facility Name (If not institution, give s.		HORNE	4b. City, Town, or	Location of Deat	MARCH	7, 20 4c. County	005 1:35 A M
	Examir	ier	SOUTHERN MARYLAN		r.		NTON	'		NCE GEORGES
	Funeral		5. Social Security Number 6. Sex	7. Age (/	In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day)		Birthplace (State or Foreign Country)
П	Director		5/9-48-9031	M 2□F	70 Yrs.	Month's Day's	Tiours William	APR. 29	,1934	GEORGIA
	land ow		Usual Residence of Decedent  10a. State 10b. County	11	0c. City, Town or Lo	ocation	<del></del>			10d. Inside City Limits
	Mary -feh	to	MD. PRINCE GE	EORGES	TEM	PLE HILLS				▼ Yes 2 No
	or 28e	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of V	What Country?
	ath wi		3420 RICKEY AVE				0748			5.A
36	d within 72 hours after death with the Maryland liene. r than "natural", or Itame 23a or 28e-1 ehow the Madical Examiner must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	<ol> <li>Was Decedent Eve Armed Forces?</li> <li>1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:</li> </ol>		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 【XNo	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)		e - American Indian, ck, White, etc. /: BLACK
21215-0036	within 72 horens. ene. than "naturalls Macical Is	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occupa kind of work done o DO NOT use retired	luring most of wor	rking		usiness/Industry
	lled w lygier her th		12 17. Father's Name (First, Middle, Last)			DRIVER	19 Mothor's Nor	ne (First, Middle, I		TRANSIT
Maryland	iould be fi Mental H varkad ot vatic ever	To Be	RICHARD	HORNE	14 10		AN	NIE MAE	HORNE	<u> </u>
Mai	d 2 sh th and 7 is n treun		19a. Informant's Name/Relationship (Typ	•		ng Address (Street a				
Baltimore,	permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygie Important: If Item 27 is marked other to any injury opother treumatic event, III ance.		MONICA CARLOS/DA  20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ Re		20b. Place of Dispo cemetery, crea	matory or other place	θ)	Date	20c. Location -	City or Town, State
Ħ	artmer partant injury		*4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Lightse	Α Δ	T	CREMATOR  2. Name and Addres		-2005	RIVERI	DALE, MD.
Ba	permi Depar Impor any ir		11.21. Cha	mlersa	$\mathcal{T}$ C	HAMBERS F 801 CLEVE	UNERAL H			
	Physician /Medical	7 1	23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line.	e death. Do not ent		g, such as cardiad	or respiratory arre	est,	Approximate Interval Between Onset and Death
8760,	cate be executed  physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c	ensequence of):	mson				
O. Box 6	the death certifi y the attending i ched for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 ☐ Live birth 2 [ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	□Ectopic pregnancy	.=		23d. Dat Mor	te of delivery nth Day Year
<b>Q</b>	uires that n signed b	þ	Part II. Other significant conditions con	tributing to death but r	not resulting in the u	inderlying cause give	en in Part I.	23e. Did tot		ribute to the cause of death?
Il Records,	The law requires that sate has been signed b page 2 should be deta	Completed						24a. Was a autops perform	y p	Were autopsy findings available onor to completion of cause of feath?
Vital	Physicien: Th rthis certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital: 🗸		Othe	25	ath (Check only on		
of	ding Phye h. After this funeral dis	tion; To	27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day Y	2 ER/Outpatier 28b. Time o Injury	f 28c. Injury Work	at	lome 5 Reside		
Division	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: Attencompletely filled in by the fune	Certification;	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (	- At home, farm, str Specify)			28f. Location (St City or Town	reet and Numb I, State)	er or Rural Route Number,
	To the Hospitel within 24 hours a To the Funeral Completely filled	Medicai C	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	icien: To the best of r er: On the basis of ex and manner stated	camination and/or in	h occurred at the tim vestigation, in my or	ie, date and place pinion, death occu	, and due to the ca irred at the time, d	ause(s) and ma ate and place, a	nner as stated. and due to the cause(s)
	To the To the Comp	Σ	29b. Signature and title of certifie	1		29c. License	1 - 0/	2	9d. Date signed	d (Month, Day, Year)
			P1	vo		DU 6	,418		3.7	-05
			30. Name and address of person who con	mpleted cause of deat	th (Item 23a) (Type,		15Rel	. clm	ton-r	ND 20735
-27	Sta Regist	-	31. Date filed (Month, Day, Year)  MAR 1 1 200	32 Registrar's	Signature	ente				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3 **Physician** 1846 M Ames Walter /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Legional 6. Sex If Under 1 Year If Under 24 H Months Days Hours Mi WICOMICO 7. Age (In yrs. last birthday)
Yrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** -983 Months Min 1 MM 2□ F 218-16-Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Mcdical Examinar must be notified at MD Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 218 32010 U.S 22 Completed by Funeral Hi 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married BIACK Saltimore, Maryland 21215-0036 1□ Yes 🖈 No Specify: Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Tsaac Construction Elementary/Secondary (0-12) College (1-4or 5+) 7th Grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked o Harri Lee P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: if item 27 is any injury or other traun 2182 daugther 10 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location · City or Town, State Burial 2 Cremation 3 Removal from State 5 ☐ Other (Specify) 21. Signature of Experal Service Licensee 22. Name and Address of Facility 500 7 W. Ix bolla 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or help failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner the burial-transit Due to (or as a consequence of): Records, P.O. Box 68760, physician use as t IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an director, page 2 autopsy performed 2 No 1 ☐ Yes Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA

Dat of Injury
(Month, Day Year) 28b. Time of Injury
28c. 4 Nursing Home 5 Residence 6 Other (Specify) this ŏ 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: Division 5 Pending investigation 1 Natural 2 Accident death. 1 Tyes 2 No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. To the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 12/05 D29105 HUDDLESTUN. M. D. CHILISTIAN completed cause of death (Item 23a) (Type, Print)

D ST. STE. 103 Ole TE. 103 SALISBURY, MD 32. Fagistrar's Signature

Registrar DHMH 17 Rev 1/2001

State

T'4 2005

			1 = For State Registrar	State of		Departmo <i>Certific</i>			nd Mental H	ygiene Reg. N	C U U 5	10297
	Dhysia	ian	1. Decedent's Name (First, Middle,	Last)					2. Date of D	eath		3. Time of Death
	Physic /Medi		Bette Lucil	lle Jones					Mar.	18ª	2005	3:15 P™
-	Exami	ner	4a. Facility Name (If not institution,	-				Location of	Death	40	. County of De	
			Citizens Nursing				Frede	erick	Allen I a a		Frede	
,	Funeral Director		209-12-7404	1 DM 2 反 F	'. Age (In yrs. last bir 8 <b>1</b>	Yrs. Mont		Hours	Min. (Month, L	irth Da <i>y, Year)</i>	9. Bi	inthplace (State or Foreign Country)
			Usual Residence of Decedent						Feb 22	., 19	24	PA
	rylan how		10a. State 10b. County	1 1 1	10c. City, Tow							10d. Inside City Limits
	e Ma	Ş	PA Fra	anklin		Wayne	sboro					1 TyYes 2 ☐ No
	or 28	Director	10e. Street and Number			10f.	Zip Code			10g. Cit	izen of What C	Country?
	s 23s	Funeral	5 <b>1</b> 5 Fairvie				17268				USA	
	ter de Itam Distri	in in	11. Marital Status	Armed Ford		13. Was De If Yes, s	cedent of Hi pecify Cuba	spanic Origi n, Mexican,	in? (Specify Yes or N Puerto Rican, etc.)	0-	<ol> <li>14. Race - Am Black, Wh</li> </ol>	
336	urs aff	by	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	lf Yes 2 If Yes, Give Year or Dat	12	1 ☐ Yes	2 🔀 No	Specify:			Specify: To	Mhite
21215-0036	within 72 hours after death with the Maryland ane. than "netural, or itams 23s or 28e-f show its Medical Examinar must be inclified at	ted	15. Decedent's	Education		Decedent's U	sual Occupa	ation		16b. K	ind of Business	
7	thin 7	ple	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4	4or 5+)	(Give kind of life. DO NO	work done d use retired	fu <i>ring</i> most ( )	of working			,
2	filed with Hygiene. other thar	Completed	12		,	Teacl	ner					care
Maryland	8 E 2 S	Be	17. Father's Name (First, Middle, La						s Name (First, Middle		Surname)	
S	should ba nd Mental markad o umatic eve	2	Earl Verd		Mabel Stit			·				
Mai	0 m m		19a. Informant's Name/Relationshi Harold H. Jones		or Rural Route Numi							
	1 and Health Iem 27		20a. Method of Disposition	s husban	. Waynesbo	_	PA 1/26 ocation - City or					
ē	Pages nent of I int: If its iry or o		1 Surial 2 ☐ Cremation 3 1 4 ☐ Donation 5 ☐ Other (Spe		ate cemeter	Disposition (I y, crematory o	r other place				•	
Baltimore,	# 된 뿐 등		21. Signature of Funeral Service Li		Rose F	lill Ce	meter	y ¦Ma	ar 23.2005	Mon	t Alto	, PA al Home, Inc.
ã	parmi Depa Impo any ii		1 Pranette V	n Ma	w				Waynesbor			
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that car	used the death. Do n	ot enter the m	ode of dying	, such as ca	ardiac or respiratory	arrest,	A 1/200	Approximate
Н	Physician		Immediate Cause (Final disease or condition	lly one cause on eat	Stroke							Interval Between Onset and Death
	/Medical		resulting in death)	a Due to (or	r as a consequence of	of):						minus
	Examiner		Sequentially list conditions	b. ————								
	pe sit	iner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying	Due to (or	r as a consequence of	of):						
	cale ba exacuted physician and the burial-transit	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c	as a consequence of	4)-						
8760,	cate ba exacul physician and the burial-trar	a E				,.						
	fficate g phys as the	edical		d								
Вох	es that the death certifi igned by the attanding be detached for usa as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco						2	3d. Date of de	livery
	death	icla	in the past 12 months? 1 ☐ Yes 2 ☒ No	4□Pregnan	h 2 Fetal death it at time of death	3 □Ectopic 5 □ Other (					Month	Day Year
P.O.	at the by the	hys	9 Unknown	9∐ Unknow								
	es thi	by	Part II. Other significant conditions	s contributing to deat	th but not resulting in	the underlying	cause give	n in Part I.	23e. Did	tobacco u	se contribute to	the cause of death?
or d	w requir baen si should I	ted							_	Yes 2	Q'No 3□Pr	obably 4 Unknown
Ö	6 S C	Completed							24a. Was	DSV	24b. Were au	stopsy findings available completion of cause of
						_			perfo 1 □ Yes	irmed? 2 No	death?	2 🗆 No
Vital Records,	Attending Physician: Thr death. sctor: After this certificate by the funeral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			1000	P - 10 - 11	Death (Check only			
	Phys rahis raldi	O 1 Yes 20 No Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other. A Nursing Home 5 Residence of Page 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe										cify)
Division of	ding I th. After funer	ţ	1 Natural 5 Pending 2 Accident investigat	(Month,		jury	28c. Injury Work	es 2⊡No	28d. Describe	now injury	occurred	
(8)	Attender r death	fica	3 ☐ Suicide 6 ☐ Could not	t be 28e. Place of	Injury - At home, fan					Street and	d Number or Ru	ural Route Number,
	el or s afte ol Dire	Certification:	4  Homicide determine	building	, etc. (Specify)		,		City or To	wn, State)		
	e Hospitel or Atten 24 hours after deatl 9 Funerel Director: etely filled in by the		29a. Certifier 1 Certifying (Check only 2 Medical Ex	Physicien: To the be	est of my knowledge,	death occurre	d at the time	, date and p	place, and due to the	cause(s)	and manner as	stated.
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	ledical		aminer: On the basi and manner	Stated.							
	To To	Σ	29b. Signature and title of certifier			2	9c. License	number		29d. Date	signed (Monti	h, Day, Year)
			,				124	3041		3-	22-0	5
1,	9		30. Name and address of person wh	o completed cause of	of death (Item 23a) (T	ype, Print)	This	Ho	re An	#	redo	el Mn
10	Sta	ia.	31. Date filed (Month, Day, Year)	Zayou 32 Reg	istrar's Signature	001	1000	V101	- Nue	/		
+ 3	Registra	ar	31. Date filed (Month, Day, Year) MAR 2 5 2	2005	ves to p	gove	•		use Ave			9

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. unpend item 23a, 27, 28a-f, perMi, 6842, 4-5-05 II

•		1- State of Maryland 1- State Registrar	/ Department of Health and M Certificate of Death		h. Na
	ysician	Decedent's Name (First, Middle, Last)		2. Date of Death Month 18, 2005	3 Time of Death (
1	Medical aminer	4a. Facility Name (If not institution, give street and number) 301 S CHURCH ST	4b. City, Town, or Location of Death SNOW HILL	4c. County of	
Fun Dire	- T	5. Social Security Number 6. Sex 7. Age ( <i>In yrs. last</i> 224−04−0598 1	t birthday) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	o Month, Day, Year)	B. Birthplace (State or Foreign Country)  Maryland
Maryland 1 show	led at		Fown or Location OW Hill		10d. Inside City Limits 1 X Yes 2 ☐ No
death with the Maryland	at be notified	10e. Street and Number 301 S. Church St. Unit 207	10f. Zip Code 21863	10g. Citizen of Wh	at Country?
₽ <del>1</del>	by Funeral		13. Was Decedent of Hispanic Origin? (Spiff Yes, specify Cuban, Mexican, Pueno 1 ☐ Yes 2☒ No Specify:	ecify Yes or No- 14. Race -	American Indian, White, etc. white
21215-0036 ad within 72 hours aff gjene. er than "natural; or	t, the Medical E.		16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)		ness/Industry
and 21 J be filed wintal Hygien ad other th	evant, the	17. Father's Name (First, Middle, Last)		Health e (First, Middle, Maiden Surname) y McMillan	
Maryland to 2 should be file the and Mental Hy 27 is marked oth	traumatic		19b. Mailing Address (Street and Number or Rura 27252 Crooked Oak Lane	al Route Number, City or Town, St	
Baltimore, Mar permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m	ry or othar	20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Plac		Date 20c. Location - Ci	ty or Town, State
Balti permit. 1 Departm Importa	any inju once.	21. Signature of Funeral Service-Licensee    Letter   Lawrey CFSP	22. Name and Address of Facility Holloway Funeral I 501 Snow Hill Rd.	Home Professiona	l Association
Physic /Medi Exami	ical	23a. Part1. Enter the disease, or compfications that caused the death. I shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Cocaine and a Due to (or as a consequent)	Do not enter the mode of dying, such as cardiac of the state of the st	or respiratory arrest,	Approximate Interval Between Onset and Death
68760, ifficate be executed g physician and	- L	Sequentially list conditions, if any, leading to immediate cause. Enter Understand Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence)  Due to (or as a consequence)			
P.O. Box 68' hat the death certificat d by the attending phy	for use a	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of death	ath 3 Ectopic pregnancy	23d. Date of Month	
cords, P.O. w requires that the de	<b>b b c</b>	Part II. Other significant conditions contributing to death but not resulting	ig in the underlying cause given in Part I.	23e. Did tobacco use contribu	ute to the cause of death?
Vital Reccidion: The law recertificate has be	r, page 2			autopsy pric dea 1.2 Yes 2 \( \triangle \trian	re autopsy findings available of to completion of cause of th?
on of ding Phys After this	ed in by the funeral director	27. Manner of Death 1 Natural 2 Accident Accident Accident 28a. Date of Injury (Month, Day Year) 3—18—05	b. Time of lnfury at Work?  In M 1 □ Yes 2√□ No M	me 5 ☐ Residence 6 ②【Other 28d. Describe how injury occurred	
DIVISION Attenuers after deat	Certific	4 Homicide determined building, etc. (Specify)	S	now HIII, MD	S Church
DIV To the Hospital or A within 24 hours after To the Funeral Direc	completely filled in by	29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. Certifier (Check only one)  29d. Medical Examiner: On the basis of examination and manner stated.	dge, death occurred at the time, date and place, a and/or investigation, in my opinion, death occurred 29c. License number	and due to the cause(s) and manned at the time, date and place, and 29d. Date signed (h	I due to the cause(s)
1	)	30. Name and address of person who completed cause of death (ftem 23	OCME	MARCH 19	
7	State	J. The light have your	111 Penn Street	Baltimore, Mar	yland 21201
Re	gistrar	MAR 2 5 2005	Goode		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
RegistramEND ITEM #21 PER FH G841 3/ Dentificate of Death Reg. No. 4 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Jane 2005 Johnston March 16 /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4h City Town or Location of Death Examiner E Kton
If Under 1 Year If Under 24 Hrs. Hospital Ceci nion Birthplace (State or Foreign Country) 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🗓 F Months Days Hours Min Yrs. Director 222-36-2017 SEPT 18. Marvland Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b County 10c. City. Town or Location 10a State Item 27 is marked other then "neturel", or items 23e or 28e-f show other treumstic event, the Muxical Examined Francisco event, the Muxical Examined Francisco event. 1 ☐ Yes 2 🔀 No Director Maryland Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours atter death with I nent of Heatth and Mental Hygiene. ont: If Item 27 Is marked other then "neturel", or Items 23e or? 43 Oakridge Court United States 21921 Funeral 14. Race - American Indian, Black, White, etc. 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 📆 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker In Her Own Home 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Surname) Be Stuart Eugene Harman Lorraine Sylvia Rakes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Importent: If Item 27 Is any injury or other treu James R. Johnston/Husband 43 Oakridge Court, Elkton, Maryland 21921 20b. Place of Disposition (Name of cametery, crematory or other place)
Delaware Veterans March 23, 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State `4 ☐ Donation 5 ☐ Other (Specify) Memorial Cemetery 2005 Bear, Delaware 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921 DONALD S. HICKS per DVR 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute Physician myocardial /Medical Due to (or as a consequence of) **Examiner** Dua to (or as a consequence of): aftery Sequentially list conditions, if any, bearing to minimize district cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Box 68760 burialphysician eq Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months?
1 Yes 2 Wo
9 Unknown Month Dav Year 4 Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 AYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 2 No 1 Yes To the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA ۵ this . Date of Injury (Month, Day 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Certification: 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide within 24 hours a To the Funerel ( 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier 29c. License number 0005519 My in 17 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD

DHMH 17 Rev 1/2001

State Registrar Alfred

31. Date filed (Month, Day, Year)

MAR 2 5 2005

Pirro

**ORIGINAL** 

Itospital

106 BOW ST

Vuion

32. Registrar's Signature

			1 - For State Registrar		State of M	larylan				lealth a	and M		giene Reg. No	21115	10300
1	Physici /Medic	al	1. Decedent's Name (First, Mic Doris	A	n n	Jane	у					2. Date of Dea Month March		<sup>y</sup> 2005	3. Time of Death 11:45 P M
<b>)</b>	Examir	er	4a. Fecility Name (If not institut Prince Georg						Ch	ever	1 y		P		George's
Ē	Funeral Director		5. Social Security Number 219-56-1494  Usual Residence of Decedent	6. Sex	M 2 X 7. A	ge (In yrs. 55	last birthday) Yrs.	Month.	er 1 Year s Days	If Under Hours	Min.	8. Date of Birtl (Month, Day Apr. 8	1 9	49 Mary	place (State or Foreign intry) 7 1 a n d
	Maryland a-f ahow	tor	10a. State 10b. Cour Maryland	PI	ince rge's	10c. Cit	y, Town or Lo		ores	tvil:	le				10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	th with the 23a or 28a	al Director	10e. Street and Number 6403 Pena	nsy1	vania A	ve.	#101	10f. 2	Zip Code 20	747			10g. Ci	tizen of What Co	untry?
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show pay injury or other traumatic event, the Modical Examples Intelliged at an ances.	Completed by Funeral	11. Marital Status  1 Never Married 2 N  3 Widowed 4 Divorce	arried	12. Was Decedent Armed Forces 1 ☐ Yes 2 X If Yes, Give Year or Dates:	?				ispanic Ori in, Mexican Specify:	gin? (Spi i, Puerto	ecify Yes or No- Rican, etc.)		14. Race - Amer Black, White Specify: B1 a	, etc.
21215-0	d within 72 ho jiene. ir then "netui the Modicel	ompleted	15. Decec (Specify only hig Elementary/Secondary (0-12	hest grade		5+)		kind of v DO NOT	ual Occup work done of use retired r Wo	during mosi ()	t of work	ing	16b. K	(ind of Business/I	ndustry
Maryland 2121	should be filed and Mental Hyger imarked other amatic event,	To Be C	17. Father's Name (First, Midd Thomas	le, Last)	Jo	hnso	n			18. Mother		(First, Middle,		Gross	
	and 2 sho Baith and n 27 is m		19a. Informant's Name/Relation				6403	Рe	nnsy	a <i>nd N</i> um <i>b</i> e	ia A	Ave. #1	r, City o	or Town, State, Z Forest	ville,MD
Baltimore,	Pages 1 ment of Ha ant: If iter iury or oth		20a. Method of Disposition  1 ☑ Burial 2 ☐ Crematic  4 ☐ Donation 5 ☐ Other		emoval from State			J o	nesC	em.3	/12/		Che		e Bch.,MD
Balt	permit. Pag Department Important: t any injury o		21. Signature of Funeral Servi	a License	Bevell	)	1 P	2. Name 451 rin	and Addres Dar ce F	ss of Facilit es B rede	ySev each rick	rell Fu Rd , MD 2		ral Hom 78	1e
Ž.	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, shock, or heart failure. LImmediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	or compli	SEPSI. Due to (or as	ine. S a c <i>on</i> seq	uence of):	Node				of respiratory ari		DVANCED	Approximate Interval Between Onset and Death
P.O. Box 68760,	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	Physiclan/Medical Exa	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	2	Due to (or as	of pregna	ancy	]Ectopic	pregnancy specify)					23d. Date of deline Month	/ery Day Year
	luires that the signed by ald be detacted	by	Part II. Other significant cond	itions cor	tributing to death	but not res	ulting in the u	nderlying	cause giv	en in Part I.					the cause of death?
Il Records,	: The law rec cate has bee page 2 shou	Completed										24a. Was a autop: perfor 1 \square Yes		prior to c	opsy findings available ompletion of cause of 2 No
Ž	iclan certifi ector	Be	25. Was case referred to med examiner?		ospital:				Oth			(Check only or			
on of	fing Phys n. Atter this funeral dir	lon: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pen	ding	1 🗷 Inpati 28a. Date of Inj (Month, Da		28b. Time of Injury	f	28c. Injun Worl	/ at </td <td></td> <td>me 5 Resid 28d. Describe h</td> <td></td> <td>6 ☐Other (Spec ry occurred</td> <td>ify)</td>		me 5 Resid 28d. Describe h		6 ☐Other (Spec ry occurred	ify)
Division of Vital	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: Atter this certificate has completely tilled in by the funeral director, page 2	Certification:	3 ☐ Suicide 6 ☐ Cou	stigation ld not be imined	28e. Place of Inbuilding, e	ijury - At ho tc. <i>(Specif</i>	ome, farm, str	M eet, facto		Yes 2 1		28f. Location (S City or Tow	treet ar n, State	nd Number or Rui e)	ral Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely tilled in	Medical C	29a. Certifier 1 Certification (Check only 2 Medical M	ying Phys al Exami	sician: To the best ner: On the basis of and manner s	of examina	wledge, death	h occurre vestigation	d at the tin	ne, date an pinion, dea	d place, th occurr	and due to the d ed at the time, d	ause(s late and	) and manner as d place, and due	stated. to the cause(s)
	To the within To the comp	Ň	29b. Signature and title of cert	fier				2	9c. License	number				ite signed (Month	
•					$\mathcal{I}$				D	581:	82	-	4.4	3-1-0	5
	5	-	30. Name and address of pers	CEDY		death (Item うの)	. 7	Print) PITA	+ 7	K	(	CHEVERLY	, A	3-7-1 1D 2018	85
*	Sta Regist		31. Date filed (Month, Day, Ye MAR 1 0 200	ar)	32. Regist	rar's Signa	iture						,		

Peggy L. Knight Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05 - 1728State of Maryland / Department of Health and Mental Hygiene State Unpend Item 23a&27 per me G842\_4-8-05 tas Death Registrar AKg Rag. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Peggy Lynn Knight March 8. 2005 4:45 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Prince George's Hospital Center Cheverly | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | April 23, ] 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 ☐ M 2 🔀 F Months 219-80-1451 45 Director 1959 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 28a-f show other treumatic avent, the Medical Examiner must be notified at Director 1XYes 2 No Maryland Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours efter death with I nent of Heelth and Mental Hygiene. ant: If Item 27 Is marked other then "naturel", or Items 23a or: 4909 52nd Avenue 20781 USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Meat Cutter 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George E. Knight Doris Stefanski 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) James D. Ricketts (Friend) 4909 52nd Avenue, Hyattsville MD 20781 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of important: If any injury or once. ⁴ 4 □ Donation 5 ☐ Other (Specify) Chesapeake Crematory 3/19/05 Beltsville, MD 21. Signature uneral Service Licensee 22. Name and Address of Facility Rendon/Hale Funeral Home 9013 Annapolis Road, Lanham, MD 20706 Denti. Enter the disease, or comprications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List god one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final Pnysician Complications Of Cervical Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) P.O. | 9 N Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by sign 1 be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 

↑ Yes 2 

No 24a Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1X Yes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes death. investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ģ 4 Homicide

Hospitel or Attending Physicien: after death Director: filled in t 124 hours a within 2 To the I

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

The best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME hi, mid March 9, 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MID LING LI

111 Penn Street Baltimore, Maryland 21201

Registrar

Medicai

			For State Registrer	State of M	Maryland / Depa	artment of H			ene	10000
			Decedent's Name (First, Middle,	Last)				2. Date of Death Month	-	3. Time of Death
	Physici /Medio		Lillie M.					March	5 2005	2:00 PM
1	Examir	ner	4a. Facility Name (If not institution,				Location of Death	1	4c. County of Death	Coordala
			Prince Geor 5. Social Security Number		tal Age <i>(In yrs. last birthd</i> ay)	If Under 1 Year	Cheverly If Under 24 Hrs.	8. Date of Birth	9 Right	George's
	Funeral Director		577-36-6322	1□M 21XF	93 Yrs.	Months Days	Hours Min.	(Month, Day, ) Apr. 5.		place (State or Foreign ntry) Th Carolina
	P		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	postion				10d. Inside City Limits
	lanyla	ō		e George's	100. City, 10wil of Ec		Capitol H	leights	'	17 Yes 2 □ No
	28e-i	Director	10e. Street and Number	2 000180 2		10f. Zip Code	- Capteon		g. Citizen of What Cour	
	h with		1917 Brooks	Dr., #101			20743		United S	States
	d within 72 hours after death with the Maryland liene. I than Insturet' or Items 23e or 28e-1 show The Medical Evan. wr must be notified at	Funeral	11. Marital Status	12. Was Deceder Armed Forces	nt Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (S in, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White,	
36	rs afte	by Fu	1 ☐ Never Married 2 ☐ Marrie 3 🔀 Widowed 4 ☐ Divorced	ed 1 □ Yes 2 € If Yes, Give 2 Year or Dates	∄No l	1 ☐ Yes 2 ☑ No	Specify:			Black
9	2 hour		15. Decedent's	s Education	16a. Dece	dent's Usual Occup	ation	16	Sb. Kind of Business/In	
215	within 7; iene. than "n	Completed	(Specify only highest Elementary/Secondary (0-12)	college (1-40	life.	kind of work done on DO NOT use retired	during most of wor d)	king		
21	filed with Hygiene. other than		7th		Но	ospital F			Priva	ate
Maryland 21215-0036	ed star	Be	17. Father's Name (First, Middle, L	•			18. Mother's Nan	ne (First, Middle, Ma	,	
IT Y	2 should be fand Mental Is marked of eumatic eve	To	Taylor Ke		19b. Mailii	ng Address (Street	and Number or Ru	Mary Be	City or Town, State, Zip	Code)
	s 1 and 2 should f Health and Men item 27 Is marke other treumatic		Mattie Willia	ms - Daugh		-			l Heights,	
Baltimore,	0 0		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	2 Demount from Stat	20b. Place of Dispo	sition (Name of natory or other plac	e)	Date 20	c. Location - City or To	own, State
Ĭ	Pages ment of ent: If it		'4 □ Ponation 5 □ Other (Sp	ecity)	△   Ft. Linco				Brentwood	i, MD
Balt	permit. Page Department of Importent: If any injury or ance.		21. Signath e of Fuheral Service L	icensee	7 ( 22				neral Home	2010
	402 40	-	23a. Part1. Enter the disease, or o	complications that caus	ed the death. Do not ent				ash., DC 20	JU19 Approximate
			shockl of heart failure. List of Immediate Cause (Final	only one cause on each	line.		9, 020 40 04.4.40	or roopilatory arroo	.,	Interval Between Onset and Death
1	Physician /Medical		disease or condition resulting in death)	_ a	ES MELLI as a consequence of):	100				
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8760,	The law requires that the death certificate be executed that been signed by the attending physician and tage 2 should be detached for use as the buriat-transit									
687	g physi as the t	Physician/Medical		d						
Вох	eath certific attending p I for use as 1	M/us	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom		Ectopic pregnancy	ı		23d. Date of delive	,
O. E	the att	sici	in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		at time of death 5	Other (specify)		***	Month	Day Year
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ita		BeC	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only one)	12.00	2
of V	d is	To	1 ☐ Yes 2 No	Hospital: 1 Inpa					ce 6 □Other (Specify	y)
on o	ing After une	lon:	27. Manner of Death  1 Natural 5 ☐ Pending		njury 28b. Time o Da <i>y Ye</i> a <i>r)</i> Injury	Worl	k?	28d. Describe how	injury occurred	
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Div	after I Dire	erti	4 Homicide determin	building,	etc. (Specify)	and reality and		City or Town,	State)	
	To the Hospitel or Al within 24 hours after of To the Funerel Direc completely filled in by	calC	29a. Certifier 1 Certifying	J Physician: To the bes	st of my knowledge, death of examination and/or in	occurred at the time	ne, date and place	, and due to the caus	se(s) and manner as st	tated.
	To the H within 24 To the Fl complete	Medic	one)	and manner	stated.					
	To with	Σ	29b. Signature and title of centuer	1 2		29c. License	/		Date signed (Month,	
7	(1)		30 Name and address of	who completed cause	f death (Itan 02-) Tree	D603	100		2-1-00	)
	(7)		30. Name and address of person w	vno completed cause of RL	3001 HOSP	TAL DR	0	HEVERLY	3-7-00 MD 2078	25
	Sta		31. Date filed (Month, Day, Year)		strar's Signature	`			100	
	Registi	ar	MAR 1 1 20	US Close	N Age	E .				

		-	For State Registrer	State of	Marylan		artment of H rtificate of I		d Mental F	Hygier Reg. f	71111	5	103	03
77.	Physicia	an	1. Decedent's Name (First, Middle, La	ist)					2. Date of Month		<sup>Day</sup> 20	3 <del>8</del> 5	3. Time o	of Death Рм
	/Medic	al.	Fate K	earney	er)		4b. City, Town, or	Location of D	M arc		4c. County of		9.20	I IVI
	Examin	er	,		<del>0</del> 1)		Bethesd		oani		Montg		У	
	Funeral			Sex 7.	Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 I	Hrs. 8. Date of (Month,	Birth	(e)	9. Birthp	olace (State ontry)	or Foreign
	Director		244-16-6672	1 🖾 M 2 🗆 F	86	Yrs.	Months Days	Hours	June			Nor	th Car	olina
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	ocation					1	10d. Inside C	ity Limits
	Maryla f sho	ō	D.C.			ashing							1 🔯 Yes	2 □ No
	r 28a-	Director	10e. Street and Number				10f. Zip Code			10g. (	Citizen of W	hat Cour	ntry?	
	h with		1351 Somerset Pl	ace N.W.			20011				USA			
	ems ermi	Funerai	11. Marital Status	12. Was Deced	es?	.S. 13.	Was Decedent of H	lispanic Origin' an, Mexican, P	? (Specify Yes or uerto Rican, etc.)	r No-		- Americ , White,	can Indian, etc.	
36	s afte	ру Е	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 🐴 Yes 2 If Yes, Give Year or Date	□No		1 ☐ Yes 2 🏝 No	Specify:			Specify:	Bla	ack	
21215-0036	thour attured		15. Decedent's E	ducation		16a. Dece	dent's Usual Occup	ation		16b.	Kind of Bus			
215	hin 73	Completed	(Specify only highest gi Elementary/Secondary (0-12)	ade completed) College (1-4	or 5+)	(Give life.	kind of work done of DO NOT use retired	during most of d)	working					
7	ed wil	Con	12th.			Admi	nistrato		None (Fine Adia				Servi	ces
Maryland	Ibe fil ntal H ed otf	Be	17. Father's Name (First, Middle, Las	t)					Name (First, Mic Lar Brad		en Sumame	"		
Ž	should nd Me mark matic	은	Richard Kearney 19a. Informant's Name/Relationship	(Type, Print)	-	19b. Mailir	ng Address (Street				y or Town, S	State, Zip	Code)	
<b>S</b>	nd 2 salth ar 27 is or treu		Christine E. Wh	eeler/dau	ghter	1366	Somerset	Pl. Wa	shingto	n, D.	.c. 20	011		
ore,	es 1 a of He of He r othe		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3	□ Removal from St	20b. F	Place of Dispo	sition (Name of matory or other plac	ce)	Date	20c.	Location - 0	City or To	own, State	
Ĭ,	Page ment ant: h		* 4 ☐ Donation 5 ☐ Other (Spec	ify)	Fo	ort Lir			-4-05		rentwo			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other then "naturel", or items 23e or 28a-f show any injury or other treumatic event, Ite Medical Evariater must be notified at once.		21. Signature of Funeral Service Lice				2. Name and Addre							
	40 = 4 Q		23a. Part Enter the disease, or cor	hall molications that cau	sed the deat		217 9th.				1, D.C	. 20	Approxima	te
			shock, or heart failure. List only Immediate Cause (Final	y one cause on eac	n line.			·g,		,,			Interval Be Onset and 7 day	Death
	Physician /Medical		disease or condition resulting in death)		ıl Fai. 'as a consec	lure, A	Acute					-	/ uay	5
	Examiner		Constitution link and distance		ertens									
	P #	iner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (or	as a consec	(uence of):						- 3		
	ecute and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or	as a consec	mence of).								
68760,	ficate be executed g physician and is the burial-transit			30010(0	40 4 0011000	(401100 01):								
687	ficate g phys	edical		d										
Вох	w requires that the death certif been signed by the attending should be detached for use a	In/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregn		∃Ectopic pregnancy	,			23d. Date		_	
	e deat he att	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No		nt at time of o		Other (specify)			_	Mon	th	Day	Year
P.O.	hat the d by t detach	Phy	9 ☐ Unknown  Part II. Other significant conditions	contributing to dea	th but not res	sulting in the u	nderlying cause giv	en in Part I	23e. D	Oid tobacc	o use contri	bute to ti	he cause of	death?
ATE Secords,	signe d be c	d by	Tattii. Ottor significant contactions	Continuating to door		anny ar are a	ingonying sause giv	J		☐ Yes		3 🗀 Prot		Unknown
AT	w requ	Completed								√as an	24b. W	/ere auto	opsy findings	available
不不多	sicien: The law certificate has b rector, page 2 sl	dwa							— a p 1 ☐ Ye	iutopsy erformedí es 2 <del>[</del> 2] /	? di	nor to co eath?	mptetion of a 2□ No	cause of
tal	en: Trificat	O	25. Was case referred to medical					26. Place of	Death (Check or		10		20110	
2 60	Physicien: this certific ral director,	To B	examiner? 1 ☐ Yes 2 🙀 No			EP/Outpatier		4 🗀 1401011	ng Home 5 🗆 F			, ,	<i>(y)</i>	
()\	Jing Phys I. After this funeral di	lon:	27. Manner of Death 1 ☒Natural 5 ☐ Pending	28a. Date of (Month)	Day Year)	28b. Time o Injury	Wor	yat k? Yes 2 □ No	28d. Descr	ibe how in	jury occurre	d		
4 RN E	ottend death ctor: , y the f	ficat	2 ☐ Accident investigati 3 ☐ Suicide 6 ☐ Could not	be 390 Place o	f Injury - At h	ome, farm, st	reet, lactory, office	163 2 110	28f. Location	on (Street	and Numbe	r or Rura	a <i>l Route Nun</i>	nber,
	el or Attending F s after death. I Director: After d in by the funer	Certification:	4 Homicide determine	building	g, etc. ( <i>Speci</i>	fy)			City or	Town, Sta	a <i>te)</i>			
m =	To the Hospitel or Attending Physicien: The within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page		(Check only 2 Medical Exa	Physicien: To the baseminer: On the base	is of examina									s)
X 18	To the within 2 To the complet	Medical	one) 29b. Signature and title of certifier	and manne	stated.	(	29c. Licens	e number		29d. [	Date signed	(Month,	Day, Year)	
	- 3 - 5		Organ			VL	D37891			Ma	arch 2	2, 20	005	
CIR	-(8)		30. Name and address of person who A. Rajvansnl, M.				Print) 1 Lane #4	·09 Rocl	kville,					
	Sta	ite	31. Date filed (Month, Day, Year)	<b>2</b> 2. Re	gistrar's Sign	ature								
e.	Registi	ar	MAR 1 1 200	5 Block	~ /K	April	W							

Marc Knight 05-01878 RJ

	1	For State Registrar	State of M	narylanu	Cei	artment d rtificate d	of Deati	and iv h		Reg. No.	005	10304
Physicia	_	1. Decedent's Name (First, Middle, Las MARC KNIGHT	st)			1			2. Date of Dea Month March	Day	Year 005	3. Time of Death 10:35 P.
/Medic Examin		4a. Facility Name (If not institution, give	e street and number	r)		4b. City, Tov	vn, or Location	n of Death	March.		ounty of Death	
LXamin		27635 Ridge Road				Dama					ntgomei	<u>-</u> Y
Funeral Director		5. Social Security Number 6. S 215 - 92 - 5324	ex 7. A □M 2□F	Age (In yrs. Ia: 35	st birthday) Yrs.	If Under 1 Y Months D	ear If Unde ays Hours	er 24 Hrs. Min.	8. Date of Birth (Month, Day 10/21/1	, Year) 969	9. Birth Cou MARY	place (State or Forei ntry) 'LAND
2 2	-	Usual Residence of Decedent  10a. State 10b. County		10c City	Town or Lo	ecation						10d. Inside City Lim
/anytan f show		WV BERKELI	Ξ Υ			NSBURG						1 ☐ Yes 2 💢 I
a or 28a-	Director	10e. Street and Number	NTE			10f. Zip Co	de 25401			10g. Citize	n of What Cou	intry?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tien 27 is marked other then "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Medical Eversires must be notified at once.	표	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Deceder Armed Force: 1  Yes 2  If Yes, Give	s? Wo	i	Was Decedent If Yes, specify			ecify Yes or No- Rican, etc.)		. Race - Ameri Black, White	, etc.
urai',	d by	3 ☐ Widowed 4 🖾 Knivorced	Year or Dates	S:							of Business/Ir	WHITE
within /2 ane. then "nat	Completed	15. Decedent's Elementary/Secondary (0-12)		or 5+)	(Give life.	dent's Usual O kind of work d DO NOT use n C TECH.	lone during m etired)	ost of work	ing		SIDENTI	,
lid be liled lental Hygie rked other lic evant, II	To Be Co	17. Father's Name (First, Middle, Last, LARRY KNIGHT	)				18. Mot		e (First, Middle, EN HEILM		umame)	
alth and M 27 is mai r traumaí		19a. Informant's Name/Relationship ( DENISE FRANCEL							al Route Numbe ARTINSBU			
Pages 1 a ent of Hez nt: If item ry or otha		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specia		te SMI	TSHBU	osition (Name of matory or other RG ATORY	of r place)	MARCH 20,	2005		ttion - City or T HSBURG ,	
Departm Importa any inju		21. Signature of Funeral Service Lice		<i></i> '	2	BROWN A	UNERAL Fac		P.O. BOX 8	321, 32 TINSBU	27 W. KI RG, WV 2	NG ST., 5402
Medical  Wedical  Whysician and  The burial-transit	al Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or if jury that initiated events resulting in death) Last	b. Due to (or a	as a conseque as a conseque as a conseque	ence of): ence of):							
To the Hospitel or Attending Physicien: The law requires that the death certificate be execut within 24 hours after death.  To the Funers after death.  To the Funers Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tran	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No		2 Fetal	death 3	⊒Ectopic pregr ⊒ Other (speci				230	d. Date of deliv	very Day Year
juires that n signed t	by	Part II. Other significant conditions	contributing to death	h but not resul	lting in the u	inderlying caus	se given in Pa	rt I.		obacco use /es 2 🗆		the cause of death?
The law requir cate has been si page 2 should	Completed								24a. Was autop perfo 1 Yes	rmed?	prior to o death?	opsy findings availa ompletion of cause 2 No
sicien: certific irector,	o Be	25. Was case referred to medical examiner?  1    Yes 2   No	Hospital:	ationt 2 7	EP/Outpatio	nt 3□ DOA	Other		h <i>(Chèck only o</i> ome 5⊟ Resid		Tother (See	ify) At sce
g Phys erthis eraldi		27. Manner of Death	28a Date of In		28b. Time o		Injury at Work?	real Sing Th	28d. Describe h			(1) IIC DCC
nding lath. r: After e funer	atio	1 □Natural 5 □ Pending 2 □ Accident investigation	n 3-14-05	5 1	10:45		1 ☐ Yes 2	<b>X</b> No	unk			
el or Attendi s after death il Director: A id in by the fi	Certification;	3 ☐ Suicide 4 ☐ Homicide  6 ★ Could not to determined	28e. Place of building,		m <b>e, farm,</b> st	reet, factory, o	ffice	D	28f. Location (S City or Tov	vn, State)	Number or Rui <b>27635</b> F	ral Route Number, Ridge Road
lospit hour unere	edicai (	29a. Certifier 1 ☐ Certifying P (Check only 2 ▼ Medical Exe	hysician: To the be miner: On the basis	est of my know	vledge, deat	th occurred at i	the time, date	and place,	and due to the	cause(s) ar	nd manner as lace, and due	stated. to the cause(s)
To the Hospitel or within 24 hours afte To the Funerel Dir completely filled in	Medi	one) 29b. Signature and title of certifier	and manner	stated.		29c. L	icense numbe			29d. Date	signed (Month	, Day, Year)
	1	/ Keodene	11. Kg	May	1.0		/L 11-1			TIGIT C.	11 1/9 4	

		-	For State	State o	f Marylan		artmen			and M		giene	0.5	10305
	Physicia	200	Registrar  1. Decedent's Name (First, Middle,		<del></del>						2. Date of Dea Month	ath Day	Year	3. Time of Death
	/Medic	al .	Madge Alberta  4a. Facility Name (If not institution,		nber)		4b. City,	Town, or	Location of		March	4c. Cou	JOO 9 unty of Death	1
ı	Lamin	۲.	Washington Cou	nty Hospi	tal		If Under	_	rstow If Under		O. Data of Bird		shingt	
	Funeral Director		5. Social Security Number 214-09-4586	6. Sex 1 ☐ M 2 🔯 F	7. Age (In yrs. 91		Months	Days	Hours	Min.	8. Date of Birth (Month, Day July 9	1913	Man	nplace (State or Foreign untry) cyland
	land ow	-	Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
	e Mary	ctor	Maryland Wash	ington		Hage	ersto							1 ☐ Yes 2 No
	with th	i Dire	10e. Street and Number 19814 Evelyn A	venue			10f. Zip	Code	217	42		10g. Citizen	of What Cou	untry?
20	be filed within 72 hours after death with the Maryland tal Hygiene. ad other than "natural", or Itams 23a or 28e-f show od other than "natural", or Itams 20a or 28e-f show event, the Madical Evanti ar Imast be notified a	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Marrie  3 ②SWidowed 4 ☐ Divorced	Armed Fo	2 <b>⊠</b> No ⁄e		Was Deced If Yes, spec		spanic Ori n, Mexicar Specify:		ecify Yes or No- Rican, etc.)		Race - Amer Black, White ecify:	
213-0030	72 hou	eted	15. Decedent' (Specify only highest	s Education grade completed)		16a. Dece	dent's Usua kind of wo DO NOT us	al Occupa	ation furing mos	t of worki	ng	16b. Kind o	of Business/I	ndustry
717	i within jiene. r than	Completed	Elementary/Secondary (0-12)	College (	1-4or 5+)		homem		,			he	r own	home
yland	ald be filed fental Hygiciked other tic event, II	To Be C	17. Father's Name (First, Middle, L Edward Latimore		n						(First, Middle, souri (			
Mary	shou		19a. Informant's Name/Relationsh Gene V. Krouse								al Route Number			
	of Healt item 2 other		20a. Method of Disposition		osition (Nar matory or c	ne of	1		Date		ion - City or			
Baitimore,	permit. Pages 1 and 2 Department of Health a Importent: If item 27 Is any injury or other tra		1 ☑ Burial 2 ☐ Cremation  '4 ☐ Donation 5 ☐ Other (Sp.	ecify)	Ro	se Hil				3/17				Maryland
g	Depar Depar Impor any ir		21. Signature of Funeral Service L	Ticenses)	new	2 - 6	2 Name ar 15 E.				MINNI( , Hage			
1	Physician /Medical		23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	ai N	caused the deal each line. TRAV (or as a consec	ENT	ter the mod	e of dyin	g, such as	cardiac	or respiratory ar	rest,	1GE	Approximate Interval Between Onset and Death
	Examiner	_	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. — Due to	(or as a consec	uence ol):								Unknown
,09/	ite be executed iysician and ne burial-transit	cai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a consec									
O. Box 68	death certifica e attending ph id for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1 □ Yes 2 No 9 □ Unknown	1 Live	tcome of pregn birth 2 - Feta nant at time of d	aldeath 3	□Ectopic p					23d	. Date of deli Month	very Day Year
Д.	juires that the dei n signed by the a lid be detached f	by	Part II. Other significant condition		eath but not res	sulting in the (	underlying (	cause give	en in Part	1.		obacco use Yes 2 N		the cause of death?
I Records,	To the Hospital or Attending Phyaician: The law requires that the within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	Completed									24a. Was autor perfo 1 Yes		4b. Were au prior to death?	topsy findings available completion of cause of
Vita	yaiclan: The is certificate hadirector, page	Be	25. Was case referred to medical examiner?	Hospital:	Innahinat a	ER/Outpatie	-t 20 D	Oth Oth	05		h <i>(Check only c</i> me 5 ☐ Resi		Other (Spec	2(6.1)
Division of Vital	nding Physith.: After this funeral di	ation: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pendin 2 Accident investig	g 28a. Date (Moi	Inpatient 2X of Injury oth, Day Year)	28b. Time of Injury		28c. Injur Wor			28d. Describe			ony)
Divis	al or Attending s after death. Il Director: After ed in by the funer	Certification:	3 Suicide 6 Could a determined	inad   208. Flac	e of Injury - At hiding, etc. (Spec	nome, larm, s	treet, factor	y, office	-		28f. Location ( City or To		lumber or Ru	ıral Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edicai		g Physician: To th Exeminer: On the and ma			nvestigation	n, in my o	pinion, de			date and pla	ace, and due	to the cause(s)
١	To the comp	×	29b. Signature and the of certifie	- 8	,	ns			e number	181			igned (Monti	h, Day, Year)
^	5H-5		30. Name and address of berson  KODUALL PE	=001-1	use of death (Ite	m 23a) (Type	, Print)	מ ניש			- HA			mD 21740
		ate rar	31. Date filed (Month, Day, Year)	6 2005	Registrar's Sign	ature A	Sparke	')		. ,	- ',' '			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month **Physician** 2005 4:50 pm Irene Kroh Inez /Medical 4b. City, Town, or Location of Deeth 4a Fecility Name (If not institution, give street end number) 4c. County of Death Examiner Washington Williamsport Williamsport Nursing Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) Funeral 1□ M 2 KF Months Days Yrs. Director Maryland 215-20-9335 Usuel Residence of Decedent June 11,1926 Peges 1 end 2 should be filed within 72 hours after death with the Merylend nent of Heelth end Mentel Hygiene. Int: If Item 27 is marked other than "naturel", or items 23e or 28e-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits other traumatic event, the Madical Examiner must be notified at 1 ☐ Yes 2 X No Director Washington Hagerstown Maryland 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? USA Be Completed by Funeral 16921 Alcott Drive 21740 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify 3 ☑ Widowed 4 ☐ Divorced White 16e. Decedent's Usuel Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Pet Supply Manufacturer Seamstress 12 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Schroyer Ruth Irene Faulders 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 21740 Carolyn Coulter - Daughter

20a. Method of Disposition

1AJ Burial 2 Cremation 3 Removal from State 12131 Heather Drive Hagerstown, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Depertment of Important: If It any Injury or concepts on concept 4 ☐ Donation 5 ☐ Other (Specify) Greenlawn Mem. Park Mar.18,2005 Williamsport,MD 21. Signature of Funeral Service Licensee Osberne Afternetterin Home, P.A. 425 S. Conococheague St.Williamsport,MD 21795 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) 2 Hours CEREBRAL Examiner Due to (or as a consequence of): Physician/Medical Examiner EREBROUZSCULAR eral Director: After this certificate hes been signed by the ettending physician end filled in by the funerel director, page 2 should be deteched for use es the buriel-trensit Hospital or Attending Physician: The lew requires that the deeth certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, BIABLITES YEARS MELLITUS Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 Ø No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were eutopsy findings available prior to completion of cause of deeth? Completed 24a. Was an eutopsy performed? 1 ☐ Yes 2 🖾 No 1 ☐ Yes 2 ☐ No Be 25. Wes cese referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 1 Yes 2 No 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. 28d. Describe how injury occurred Injury at Work? 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 3 Suicide 6 Could not be determined Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examíner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 To the I 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 33700 March 15 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) Howe WILLIAMSPORT

DHMH 16 Rev 6/95

State Registrar 120

31. Date filed (Month, Day, Year)

N. ARTIZAN

54

32. Registrer's Signature

			1 - For State Registrar	State of		partment of ertificate of		and Mental Hy	giene Reg. No. 2	5 10307
	Physici	an	1. Decedent's Name (First, Middle,					2. Date of De Month	Day Ye	3. Time of Death
	/Medic		Margaret Elle					March	19 20	05 0631 AM
	Examin	er	4a. Facility Name (If not institution,			4b. City, Town,			4c. County of D	
			Washington Cour  5. Social Security Number		Age (In yrs. last birthda		erstow r   If Under			ington  Birthplace (State or Foreign
	Funeral Director		218-38-1687	1 □ M 2 💢 F	92 Yrs.	Months Day		24 Hrs. 8. Date of Bin Min. (Month, Da July 6,	1912 M	Country) aryland
	ъ		Usual Residence of Decedent							ar y rand
	anylar show	_	10a. State 10b. County		10c. City, Town or					10d. Inside City Limits
	he Mi	Director		ngton	Smit	hsburg				1 ☐ Yes 2 💽 No
	3a or 2	Dir	10e. Street and Number 13647 Edgemont	Rd.		10f. Zîp Code	21783		10g. Citizen of What	Country? S.A
	death ms 2	Funeral	11. Marital Status	12. Was Decede	ent Ever in U.S.	3. Was Decedent of	Hispanic Ori	igin? (Specify Yes or No n, Puerto Rican, etc.)	- 14. Race - A	merican Indian,
36	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or Items 23a or 28a-f show eny injury or other treumatic event, Ite Medical Examiner must be notified at once.	by Fu	1 ☐ Never Married 2 ☐ Marrie 3 🛣 Widowed 4 ☐ Divorced	Armed Force d 1 Tes 2 If Yes, Give Year or Date	<b>△</b> No	1 ☐ Yes 2 No			Specify:	thite, etc. White
9	2 hou	ted	15. Decedent's	Education	16a. Dec	edent's Usual Occi	upation	A of condition	16b. Kind of Busine	ss/Industry
21	thin 7 e.	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-4	lite	ve kind of work don DO NOT use retir	e during mos ed)	t of working		
7	ed wi ygien ner th	Con	8			Homema				ome
Maryland 21215-0036	d be fill	Be o	17. Father's Name (First, Middle, La Jesse Amos I				18. Mothe	er's Name <i>(First, Middle,</i> Clara Bell		
Ž	should nd Me mark matic	To	19a. Informant's Name/Relationshi		19b. Ma	iling Address (Stree	et and Numbe	er or Rural Route Numbe		e. Zip Code)
	s 1 and 2. of Health ar item 27 is		Elwood H. Leathe	er (Son)				Smithsburg		
ore,	ss 1 a of Hea item		20a. Method of Disposition		20b. Place of Dis	position (Name of rematory or other pl		Date	20c. Location - City	
Ë	Page ment ant: H		¹X☐ Burial 2 ☐ Cremation 3 `4 ☐ Donation 5 ☐ Other (Spe		1(0)	Cemeter	1 4	March 23, 2005	Ringgold	,Md.
Baltimore,	permit. Departi Importi eny inj		21. Signature of Funeral Service Li	censee		22. Name and Add			525 Bradbu	
_	40 E 9 0		Jellie /	ec 114				ral Home Sm		
i	Physician /Medical		22a. Part1. Enter the disease, or c shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	aA	UTE FEN				rrest,	Approximate Interval Between Onset and Death
	Examiner				as a consequence of): - V S & P & I &	1041	YDRI	ATION		
		ner	Sequentially list conditions, it any, leading to infinediate cause. Enter Underlying Cause (Disease or injury	D. —	as a consequence of).					
	icate be executed physician and s the burial-transit	Examiner	that initiated events	С.						
30,	oe execian a		resulting in death) Last	Due to (or	as a consequence of):					
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P.O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		n 2 ☐ Fetal death 3 t at time of death 5	□Ectopic pregnan □ Other (specify)	су		23d. Date of Month	delivery Day Year
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oro	w require been si should b	etec	Kenenia (							Probably 4 Donknown
Division of Vital Records,	rsicien: The taw s certificate has b lirector, page 2 s	Completed by	FALURG		)		-	autop perfoi	sy prior	
ita	sien: artifica ctor. I	Bec	25. Was case referred to medical examiner?		,		26. Place	of Death (Check only o		
× ×	hysic this ce	2	1 ☐ Yes 2 ☐ Mo	Hospital: 1 Dunp		BIIL JU DOA		rsing Home 5 - Resid	dence 6 Other (S	pecify)
n o	Attending Physicien: r death. sctor: After this certifics by the funeral director.	OU:	27. Manner of Death  1 Natural 5 Pending	28a. Date of I (Month,	njury 28b. Time Day Year) Injury	W			now injury occurred	
Sic	Attendi death. ctor: A y the fu	icat	2 Accident Investiga 3 Suicide 6 Could no	t be	Initiate At home form		Yes 2 1		N	Control Control Market
<u>≥</u>	l or A after Direction by	Certification:	4 ☐ Homicide determin		Injury - At home, farm, setc. (Specify)	street, factory, onice	•	City or Tow		Rural Route Number,
	spite hours nerel / filleo		29a. Certifier Certifying	Physician: To the be	est of my knowledge, de	ath occurred at the	time, date and	d place, and due to the	cause(s) and manner	as stated.
	To the Hospitel or Attending Physicien: The within 24 hours after death.  To the Funerel Director: After this certificate his completely filled in by the funeral director, page	Medical	one)	taminer: On the basis and manner	s of examination and/or	investigation, in my	opinion, deal	th occurred at the time, o	date and place, and o	lue to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier			29c. Licer	se number	7	29d. Date signed (Mo	onth, Day, Year)
Ala,			· Ub			1)6	202	7	3/19/0	
	3			Bansal		Print)	eet	Hagersto	wn Me	cryland
	Sta Registr	* 4	31. Date filed (Month, Day, Year) MAR 2 5 200	MI.	strar's Signature	the state of the s				

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 5:15 PM MARCH 8 2005 ROSE ANN LANFRANCHI /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** ANNE ARUNDEL ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Months 1 □ M 2 X F 1923 NY DEC. 21, 81 Director 103-18-5847 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County Wode I ral', or Items 23a or 28a-f ehov Examiner must be notified at 1 ☐ Yes 2 X No Director QUEEN ANNE'S CHESTER MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number **USA** 21619 1514 POSTAL ROAD death by Funeral 14. Race - Americen Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ▼ No 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 Married 1 Yes 2 No WHITE Maryland 21215-0036 Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced ear or Dates: natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry The Madical 15. Decedent's Education (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4or 5+) Il Hygiene. OWN HOME 12 HOMEMAKER 7 le marked othe traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be ANTOINETTE PETRIZZO JAMES STAVOLA ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health at Importent: if Item 27 leany injury or other traconce. 1514 POSTAL ROAD, CHESTER, MD 21619 ANTHONY LANFRANCHI/HUSBAND Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition CHESAPEAKE CREMATION 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 03/11/2005 STEVENSVILLE, MD <sup>¹</sup> 4 □Donation 5 □ Other (Specify) CENTER permit. FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 21. Signature of Funeral Service Licenses fulli Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) talle **Physician** pirator /Medical Due to (or as a consequence of): **Examiner** une cance Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed Exami burial-tran Due to (or as a consequence of) attending physician Box 68760 Physician/Medical the use as t IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) o. 9☐ Unknown ٦. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 4 Unknown 3 Probably 1 ☐ Yes 2 ☐ No been sig Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy certificate has 1 ☐ Yes 2 ☐ No 2 PNO 1 ☐ Yes or Attending Physician: funeral director. 26. Place of Death Check on one 25. Was case referred to medical Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဥ 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: After 1 Natural 5 Pending investigation To the Hosping.
within 24 hours after death.
To the Funerel Director: Aft 1 ☐ Yes 2 ☐ No М 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only onel 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2386

Registrar DHMH 17 Rev 1/2001

State

130 Love Pn:

KOAD

Stevensville MD 21666

umnWulsh mD

THOMAS WALSH MD

AR 10

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2005

			For State Registrar	State of	Maryland / Dep	partment of I			iene <sub>eg. No.</sub>	5 10309
П	Physici	an	1. Decedent's Name (First, Middle	, Last)				2. Date of Deat Month	Day	3. Time of Death
	/Medic		Herbert V			45 City Town	or Location of De	March 6	5,2005 4c. County of	10:35 P <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution 4817 Main Str	-	er)		onville	atri		Anne's
	Funeral		5. Social Security Number	6. Sex 7.	Age (In yrs. last birthda	y) If Under 1 Year	If Under 24 H	Irs. 8. Date of Birth		Birthplace (State or Foreign Country)
	Director		212-32-7880	1 <b>X</b> M 2□F	67 Yrs.	Months Days	Hours M	6-14-1	937	Maryland
	pu kee		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	Aaryla f shor	ō		Anne's	Grason					1 □ Yes 2 ☐ <b>X</b> No
	the 7	rect	Maryland Queen  10e. Street and Number	Airie S	GLason	10f. Zip Code		1	0g. Citizen of W	hat Country?
	h with	al D	4817 Main Stre	et		2163	8		USZ	A
36	a within 72 hours after death with the Maryland jiene. r than "natural", or items 23a or 28a-f show the Modical Examiner must be nailfied at	by Funeral Director	11. Marital Status  1 □ Never Married 2 X Marria 3 □ Widowed 4 □ Divorced	If Von Cino	□No	3. Was Decedent of If Yes, specify Cub		(Specify Yes or No- erto Rican, etc.)		- American Indian, K, White, etc. White
21215-0036	2 hou	ted	15. Deceden	t's Education	16a. Dec	cedent's Usual Occu	pation	working	16b. Kind of Bus	siness/Industry
215	thin 7 e. an "n	Completed	(Specify only higher Elementary/Secondary (0-12)	College (1-4	life	ve kind of work done  . DO NOT use retire	ed)	WOIKING		
	T1 100 to 100		11th 17. Father's Name (First, Middle,	( ast)	Heav	y Equipme		ator Name (First, Middle, 1		ruction
and	t be filed ntal Hyg ed othe event,	Be	Clifford L	•				a Shipe	vialgeri Darriame	•/
Maryland	2 should be to and Mental Is marked or aumatic eve	ပ္	19a. Informant's Name/Relations		19b. Ma	iling Address (Stree	<del>_</del>	Rural Route Number	r, City or Town, S	State, Zip Code)
	alth ar 27 is r trau		Joy Loughry/ W	ife	481	7 Main St	reet, Gr	casonville	, MD 216	538
ore,	of Hei		20a. Method of Disposition 1 □ Burial 2 □ Cremation		20b. Place of Dis	position (Name of rematory or other pla	ace)	Date	20c. Location - 0	City or Town, State
Ë	Page ment ant: If ury o		`4 □Donation 5 □ Other (S		Kalas	Crematory			Edgewate	
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ea 2006.		21. Signa for of Funeral Service	un			mons Isl	Land Rd. E	dgewate	Funeral Home r, MD 21037
	Pnysician		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	only one cause on each	ch line.	enter the mode of dy	ing, such as care	diac or respiratory arr	est,	Interval Between Onset and Death
68760,	death certificate be executed  Medical Examine the attention of tor use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Livaseas or frigury that initiated events resulting in death) Last	b. Due to (or Due to (or d	r as a consequence of): r as a consequence of): r as a consequence of):	= Aureo	n			1 month
.O. Box 6	at the death certific by the attending p tached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birt	nt at time of death	3 □Ectopic pregnand 5 □ Other (specify)	су		23d. Date Mon	e of delivery th Day Year
<u>α</u>	es the	by	Part II. Other significant condition of the significant condition of the significant conditions	ons contributing to dea	th but not resulting in the	a underlying cause g	iven in Part I.			ibute to the cause of death?  3 Probably 4 Onknown
al Records,		Completed	,					24a. Was a autop perfor 1 Yes	sy p med?/ d	Vere autopsy findings available rior to completion of cause of eath?
Vital	Physician: This certificated ral director, p	Be C	25. Was case referred to medical examiner?	Hospital:	patient 2 ER/Outpat	tient 3 DOA	26. Place of I	Death (Check only o	ence 6 □Othe	or (Canaiki)
of		on: To	1 Yes 2 No  27. Manner of Death 1 Matural 5 Pendi	28a. Date of (Month)		e of 28c. Inju	4 🗀 14013111	28d. Describe h		
Division	deat deat ctor:	Certification:	2 Accident invest 3 Suicide 6 Could 4 Homicide determ	not be 28e. Place of	of Injury - At home, farm, g, etc. <i>(Specify)</i>			28f. Location (S City or Tow		er or Rural Route Number,
	To the Hospital or A within 24 hours after To the Funeral Dirac completely filled in by	Medical C			pest of my knowledge, de sis of examination and/or or stated.					
	To th Within To th compl	Me	29b. Signature and title of certific	1/101 -11	//	'>	nse number	2	29d. Date signed	(Month, Day, Year)
7			1/1 N-/	we m	of death (the see) (T	7 . 0	303		2101	U.)
			30. Name and address of person				nnamlia	. MD 2140	21.78	
	St. Regist	ate	Marco A. Mej 31. Date filed (Month, Day, Year MAD A		2002 Medica Distrar's Signature	A. W.	mrdWTT2	FID 2140		
	riegist		I MAR V	J LUUJ						

		,	1 - For Stata Registrar		f Marylar		artment of H			Ra	19. No. 200	5 10310
	Physici /Medic	al	Decedent's Name (First, Middle,  Barney  4a. Facility Name (If not institution,	н.	mbarl	L	epovetsky 4b. City, Town, or		М	Date of Death Month arch	Day Yea 2005	9:40A M
	Examin	ier	Lorean Health	Care Cent	ter		Mount A			D. (Dist	Carrol:	L
	Funeral Director		191-10-8223	5. Sex 121 M 2 ☐ F	7. Age (In yrs. 102	Yrs.	Months Days	Hours	Min. S	Date of Birth (Month, Day, ept. 22	Year) 1902 Ma	hirthplace (State or Foreign Country) assachusetts
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or itams 23a or 28a-1 show any injury or other traumatic event, the Medical Evaluation must be routified at 2008.	To Be Completed by Funeral Director	Usual Residence of Decedent  10a. State  10b. County  Maryland Freder  10e. Street and Number  3326 Lowell La  11. Marital Status  1	12. Was Dec Armed Fi 1 Yes if Yes, of Year or E Education grade completed)  College ( ast)  tsky p (Type, Print) sky — Data Grade Completed) completed or the print of the pri	edent Ever in Uproes? 20 No verates:  1-4or 5+)  State Me  Caused the deal	16a. Decedifie.  Mailinin-1aw Place of Disposemetery, creit	Note that the second of the se	spanic Origin, Mexican, Specify: ation furing most 18. Mother Rose and Number well I e) atoric spot Facility Leswor e Rose	in? (Specification) in? (Specification) in? (Specification) in? (Specification) of working to a sum of working the post of the	ty Yes or No- can, etc.)  First, Middle, M tsman Route Number, 1 1 1 1 2 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2	Og. Citizen of What U.S.A.  14. Race - Ar Black, Wi Specify: WI 16b. Kind of Busines  Store Maiden Surname)  City or Town, State SVIIIe. M. 20c. Location - City Alexandr: Ineral Horis, Marylan	10d. Inside City Limits  1 □ Yes 2 No  Country?  merican Indian, nite, etc.  nite ss/Industry  n, Zip Code)  nryland 21754 or Town, State  ia, Virginia ne
,/60,	Physician /Medical Examiner  Examiner  but a prize as the prize result is near the prize result.	ical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Inderlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to	(or as a consector as a consector as a consector)	quence of):						3 Days
.O. Box 68	death certific e attending p d for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live	tcome of pregn birth 2  Feta nant at time of d	al death 3[	Ectopic pregnancy				23d. Date of o Month	delivery Day Year
rds, P	w requires that been signed b should be deta	by	Part II. Other significant condition Dementiq	ns contributing to o	leath but not res	sulting in the u	nderlying cause give	en in Part I.				to the cause of death?  Probably 4 □Unknown
Records,	The law requires that the site has been signed by the bage 2 should be detache	Completed								24a. Was ar autops perform 1 Yes 2	y prior t ned? death	autopsy findings available o completion of cause of ?
Division of Vital	I or Attending Physician: The law after death. Diractor: After this certificate has b it in by the funeral director, page 2 s	Certification; To Be C	25. Was case referred to medical examiner?  1  Yes	28a. Date (Moration of be 28e. Place	nth, Day Year)	28b. Time o Injury	f 28c. Injun Work	er: 4 Nur	rsing Home 28 No	Check only one  5  Reside  d. Describe ho	nce 6 Other (S) w injury occurred	pecify) Rural Route Number,
]	To tha Hospital or Attent within 24 hours after deat To tha Funaral Diractor: completely filled in by the	Medical Ce		xaminer: On the b			vestigation, in my o	pinion, death	h occurred	at the time, da	tuse(s) and manner ate and place, and d	ue to the cause(s)
	3		30. Name and address of person v		se of death (Ite	470	Print)	70'11		A	3-11-0 Frederic	l. lan
	Sta Regist		31. Date filed (Month, Day, Year)	1 2005 32.	gistrar's Sign	aturet	LOCK .	MOL	se t	The	Frederic	ic ivij

State of Maryland / Department of Health and Mental Hygiefie | Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 13 2005 ear MARCH Harry Leventhal 6:20 AM M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner QUEEN ANNE'S CENTREVILLE CORSICA HILLS NURSING HOME If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, ) Nov. 21, 9. Birthplace (State or Foreign Country) New Jersey Year) 1912 **Funeral** 1 XM 2 F 92 179-34-6576 Yrs Director Usual Residence of Decedent the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow event, the Medical Examiner must be notified at Pennsylyania Bucks Levittown, 1 AYes 2 No Director 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? ö 282 Lakeside Drive East 19054 USA or itams 23a Funerai death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces 11 Marital Status 14. Race - American Indian. Black, White, etc. filed within 72 hours after ☐Yes 2☐No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No White Specify: þ If Yes, Give Year or Dates: Specify: 3 Widowed 4 □ Divorced "naturel". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) then Elementary/Secondary (0-12) College (1-4or 5+) permit. Peges 1 and 2 should be filed w Department of Health and Mental Hygien Important: If Item 27 is marked other the eny filjury or other traument 12 Postal Worker U.S. Govt. Postal Ser 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ralph Leventhal Bessie Halpern 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 143 Charnor Manor Blvd. Chestertown, MD 21620 Dennis A. Leventhal/ son 20b. Place of Disposition (Name of cometery, crematory or other place)

Chesapeake Cremation Cntr. 3/14 stevensville, MD 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Fellows, Helfenbein, Newnam FUneral Hm. PA Kick 130 Speer Rd. Chestertown, MD 21620 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Attending Physician: The law requires that the death certificate be executed burial-transit etusion igned by the attending physician and be detached for use as the burial-tran resulting in death) Last (br as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Inknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed? certificate 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Yes 2 No 2 ER/Outpatient 3 DOA this the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 - Homicide 50 24 hours 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 To the 29b. Signature and title of certifie 29c. License number 29d. Date, signed (Month. Day, Year) XX 6130 30. Name a ress of preson ed cause of death (Item 23a) (Type, Print) 120 Speer Road, Chestertown, MD 31. Date filed (Month, Day, Year) 32. Regetrar's Signature State

Registrar

2005

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		State Registrar		t. ( 4)					jer	tificat	e of L	Deatr	7	2. Date of		3. No.)	AF	11-03-1	2
Physicia	an	Decedent's Name	John	ie, Lasij	CI	nerm	040		т	anden	horao	r		Month	Death	Day 5	Year O 5	2:15 A	.tng
/Medic Examin		4a. Facility Name (/		n, give stre			1	1	Ť				of Death	03		4c. Count			
Examin	ei	Sacre	dH	eart	Ho	Sp	ita		4- 3	C tu	mb		ar 24 Hrs.	d	Di at	Alleg	, ,		<del></del>
Funeral Director		5. Social Security N 212-24-018	39	6. Sex 1 ☑ M	2 🗆 F		77	last birth		Months	Days	Hours		8. Date of I (Month, 09/11/	Dav. Y	(ear) 7	COL	place (State or For intry) sylvania	reign
and w	}	Usual Residence of 10a. State	10b. County	,			10c. Cit	y, Town	or Loc	ation								10d. Inside City Lie	mits
Maryla	tor	MD	1	Allega:	ny					rland								1 ∑ Yes 2 □	
or 28s	Director	10e. Street and Nur	mber							10f. Zip	Code				100	g. Citizen of	What Cou	intry?	
ath wi		1	14 Karn									1502				USA			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event. Ite Medical Examination that the confiled at once.	by Funeral	<ol> <li>Marital Status</li> <li>Never Marri</li> <li>Widowed</li> </ol>		rried	Was Dece Armed For 1 XYes If Yes, Giv	rces? 2 🔲 No	0	.s. /II		Vas Dece Yes, spe □Yes				ecity Yes or look Rican, etc.)	No-		ck, White		
tural al Ex	ed b	3 - Widowed	15. Deceder		Year or Da	ates:		16a. D	eced	ent's Usu	al Occup	ation			16	Sb. Kind of E		√hite ndustry	
within 72 ene. than "na	Completed	(Spec Elementary/Seco 11	cify only highe			-4or 5-	+)	(	Give k ife. D		rk done d se retired	during mo	st of work	king			sporta		
filed Hygi other ent.	Be Co	17. Father's Name	(First, Middle,	, Last)									ner's Nam	e (First, Midd	tie, Ma		-	iczon .	
uld be Aental rked ric ev	To B	Ernest		1	Webster	r	L	ander	ıber	ger		Не	len	Gou	ıld		Show	man	
id 2 shoill the and N		19a. Informant's Na Anna Lee						1						ra <i>i Route Nun</i> and, MD	21.		, State, Zi	o Code)	
s 1 ar		20a. Method of Dis					20b. P	Place of Commentery	Dispos	sition (Nau	ne of ther plac	(e)		Date	20	Oc. Location	- City or T	own, State	
Page nent ant: If ury or		1 ☐ Burial 21 `4 ☐ Donation			oval from S	State		-		Crema				6/2005		Cumberl	,		
permit. Departr Importa any inju		21. Signature of F	neral Service	Licensee	land				22.	Name ar				lams Fam rect, Cu				e, P.A. 502	
		23a. Part1. Enter t	he disease, o	r complicat	tions that ca	aused	the death	h. Do no	t ente	or the mod		-			_			Approximate	
Physician /Medical Examiner		shock, or hea Immediate Cause disease or condition resulting in death)	(Final	a	Ac	nt	le	M uence of		OCA	red 1A	H	Ty	Frac	710.	N		Interval Between Onset and Death	e
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tificate ng phy as the	ledic																		
law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medica	IF FEMALE: 23b. Was deceden in the past 12 1 Yes 2 9 Unknown	months? □ No	23c.	If yes, out 1 Live b 4 Pregn 9 Unkno	irth a ant at t	2 ☐ Feta	l death		Ectopic p Other (sp							ate of delivionth	ery Day Year	
res that the de signed by the a be detached f	y Ph	Part II. Other signif	ficant conditi	ions contril	buting to de	ath bu	t not res	ulting in t	he un	derlying o	ause give	en in Part	:1.	23e. Di	d toba	cco use con	tribute to	the cause of death	?
w requires been sign should be	ed by	<u>Sci</u>	rere	de	m en	to	9							1 (	] Yes	2 <b>2</b> No	3 ☐ Pro	bably 4 □Unkno	own
9 C 9	Completed													pe	topsy rforme	ad?	prior to co death?	opsy findings available on pletion of cause	able
ician: Th certificate rector, pag	0	25. Was case refer	red to medica	al								26 Plac	e of Deal	th (Check onl		2No	1 🗆 Yes	2 No	
Physician: r this certific ral director,	OB	examiner? 1 Tes 2			pital:	npatier	nt 2 🗆	ER/Outp	atient	3 DC	Othe			ome 5 Re			her (Speci	fy)	
Jing After fune	tlon; T	27. Mann Deat  1 atural 2 Accident	5 Pendi		28a. Date o (Mont	of Injun	Year)	28b. Tir Inji		M 2	8c. Injun Worl	yat k? Yes 2	] No	28d. Describ	e how	inj <b>ury</b> occu	rred		
P Str	ertification;	3 Suicide 4 Homicide	6 Could deter		28e. Place buildir		ry · At ho . (Specify		n, stre	et, factor	, office			28f. Location City or 1			ber or Rui	al Route Number,	
Ho:	edical C	29a. Certifier (Check only one)	1 ☐ Certifyi 2 ☐ Medicai	ng Physic I Examiner	ian: To the On the band man	isis of	examina	wledge, tion and/	death or inv	occurred estigation	at the tim	ne, date a pinion, de	and place, eath occur	and due to the	e, date	se(s) and m a and place,	anner as	stated. to the cause(s)	
To the within 2 To the complet	Me	29b. Signature and	I title of certific	er M	1/	v				29		e number		0:	1	I. Date signe			
1/IVA		20 Name	/	///	V le	90	me	1/	m	Print)	9	Di	22	181	M	1 ARCI	4 5	21502	5
nds		30. Name and addr	ress of person	1	on er	_	92.5	123a) (T	ype, F	rint)	4/1.	sh E	) - C	um la e	10	nd A	11	21502	
// /CA	te	31. Date filed (Mon	nth, Day, Year	7		_	r's Signa	iture	UPI	P	VV (LI)	J 11 P	VI., L	WIN KIC	14	non	1 Ch.	DEIDUSC	

State Registrar

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit . To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

DHMH 17 Rev 1/2001

MAR 0 7 2005

			For Stete Registrar	State of Mar		artment of F			giene () (	5	10313
	° Physic	ian	Decedent's Name (First, Middle, Last Owen.	Alvin				2. Date of Dea Month	Day	Year	3. Time of Death
	/Medi	cal	4a. Facility Name (If not institution, give			Layman	r Location of Death	03	4c. County	of Dogth	1200 PM.
	Examir	ier	Socred Hear	t Hospi	tal	Cumk	(		1 1	gan	<b>Y</b>
	Funeral Director		5. Social Security Number 6. Se	x 7. Age	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Da) 12/14/19		J	lace (State or Foreign
			Usual Residence of Decedent					12/11/1/		11111	and
	show	-	10a. State 10b. County  MD Allegany	1	10c. City, Town or Lo					1	Od. Inside City Limits
	the M	Director	10e. Street and Number		- U	umberland					1 XYes 2 No
	with Ba or	D.	10 N. Liberty St	root		10f. Zip Code			10g. Citizen of V	/hat Coun	try?
	death ms 2;	Funerai	11. Marital Status	12. Was Decedent Ev		21502 Was Decedent of H	ispanic Origin? (Sp	ecify Yes or No-	USA 14. Race	- Americ	an Indian,
920	ges 1 and 2 should be filed within 72 hours after death with the Maryland to Health and Mental Hygiene. If item 27 is marked other then "neturel", or items 23a or 28e-1 show or other treumatic event, tra Medical Exactrating the inclined at	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ∑Yes 2 ☐ No If Yes, Give Year or Dates:	1942-	f Yes, specify Cuba 1 □ Yes 21√2 No	n, Mexican, Puerto Specify:	Rican, etc.)		k, White,	
21215-0036	72 hou	Completed	15. Decedent's Edu (Specify only highest grad	ication	16a. Dece	dent's Usual Occup	ation		16b. Kind of Bu	siness/Inc	Justry
21	ithin 7	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	lite.	DO NOT use retired	during most of work f)	ing			
	led w tygier her th		9		]	aborer			Munici	-	
Maryland	12 should be filed within h and Mental Hygiene. 7 Is marked other then "treumatic event, It a Men	o Be	17. Father's Name (First, Middle, Last) Alvin		Layman		18. Mother's Name Edith	e (First, Middle,	Maiden Sumam Hag	•	
ary.	shoul nd Me mark	2	19a. Informant's Name/Relationship (T	/pe, Print)		ng Address (Street	and Number or Run	al Route Numbe			Code)
	and 2 salth a n 27 is	1	Bernadette M. Ross /	daughter			oad, Cumber		21502		
Jre,	as 1 a of Hea of Hea litem		20a. Method of Disposition		20b. Place of Dispo			Date	20c. Location -	City or To	wn, State
<u>Ë</u>	Pages ment of I ent: If its ury or o		1  Burial 2  Cremation 3  1 `4  Donation 5  Other (Specify,		Restlawn Me			/2005	LaVale	, MD	
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If item 27 li eny injury or other tre		21. Signature of Juneral Service Licens	lans	22		ss of Facility Ada:	-			P.A.
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the	ne death. Do not ent					7.	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	. Septice	mia S	to obul	COCCU	S ALIE	2110		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):	11/19/10	TO COLD.	- 101			113/1/185
		<u>.</u>	Sequentially list conditions,	b. Dua to for as a	consequence of):						
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events								
oʻ	exec an and rial-tra	Exa	resulting in death) Last	Due to (or as a	consequence of):						
8760,	cate be executed physician and the burial-transit	dicai		d							
9	death certifica attending ph d for use as the	O I	IF FEMALE:					-			
Вох	attend for us	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1☐Live birth 2	☐Fetal death 3☐	Ectopic pregnancy			23d. Date Mor	of delive	ry Day Year
o.	that the de ed by the a detached i	ysic	1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at tir 9☐Unknown	ne of death 5L	Other (specify)					,
Ω.,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by Ph	Part II. Other significant conditions co	ntributing to death but	not resulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use contr	bute to th	e cause of death?
Records,	w requires been sig should b							1 🗆 Y	es 2 🗆 No	3 🗌 Proba	ably 4 Munknown
၀၁	e law requ has been je 2 shoul	Completed						24a. Was a	an 24b. V		osy findings available
E E		E O						autop: perfor	med? d	eath?	npletion of cause of
Vital	sicien: Th certificate irector, pag	Be (	25. Was case referred to medical examiner?				26. Place of Death				
of	hys this al dii	2	1 192 5 V 140	dospital:			4 🗆 Nulsing 110				)
	After After fune	tion	27. Manner of Death  1 Anatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day )	(ear) 28b. Time of Injury	Worl	/at k? Yes 2 □ No	28d. Describe h	ow injury occurre	bd	
Division	r Attending er death. rector: After by the fune	fica	3 Suicide 6 □ Could not be	28e. Place of Injury	r - At home, farm, str			28f. Location (S	treet and Numbe	or Or Rural	Route Number
Dİ	s after s after al Dire	Certification:	4 ☐ Homicide determined	building, etc.	r - At home, farm, str (Specify)		Į.	City or Tow	n, State)		
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Medicai (	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of ner: On the basis of ea and mappier state	xamination and/or inv	occurred at the tin restigation, in my o	ne, date and place, pinion, death occurr	and due to the c ed at the time, d	ause(s) and mar ate and place, a	ner as stand	Ited. the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	15		29c. License	e number	2	9d. Date signed	(Month, E	Jay, Year)
1	INA		· US	1/1/1		DI	0154	63	mont	10	2. 2005
Pel	D. B.		30. Name and address of person who of			,	V 13 Y		· ·		11000
V	hs on		DR, Shin Kim 31. Date filed (Month, Day, Year)	90 MA		eet, We	rsternp	ort, M	10 SI:	562	
	Sta Regista	_		32. Revistrar	oignature /	both					

			For	,400	State o	f Maryla	•	artment of			ental Hy	giene	00=	1.0	
			- State Registrar				Ce	rtificate of	Death		- 5 - 75	Reg. No.	005		3 4
	Physici		Decedent's Name (First, Mi		t)						2. Date of De Month	Day	Year	3. Time of I	Death M
	/Medic Examin	al -	Dorothy Agnes  4a. Fecility Name (If not institu		street and nu	mber)		4b. City, Town,	or Location of	of Death	Ma	4c. Co	2005 unty of Death	10:50 P	
			St. Vincent de P			enter		) If Under 1 Yea	Frostb		0.0		gany	(2)	
П	Funeral Director		5. Social Security Number 214-07-5996	6. Se	X □M 2 <b>5</b> 2)F	7. Age (In y)	rs. last birthday Yrs.	Months Days		Min.	8. Date of Big (Month, Da	ay, Year)	Cou		roreign
	ס		Usual Residence of Decedent								13-Jan	1318		sylvania	
	arylan ehow	_	10a. State 10b. Cou	nty			City, Town or L	ocation.						10d. Inside City 1 ☐ Yes	
	he M.	Director	40 - Chapt and Number	arrett		Fro	ostburg	10f. Zip Code				10a Citizen	of What Cou		P
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene Important: If item 27 is marked other than "netural", or Iteme 23e or 28e-f ehow any injury or other traumatic event, Ira Madical Exartinar must be nufficed at ODGE.	ΪΩ	209	1 Finz	el Road								or what ood		
	death me 2%	Jera	11. Marital Status		12. Was Dec		U.S. 13.	Was Decedent of If Yes, specify Cu	Hispanic Ori	igin? (Spec	cify Yes or No	U.S.A.	Race - Ameri		
ဖွ	after or Ite	Completed by Funeral	1 Never Married 2 1		Armed Fo 1 ☐ Yes If Yes, Gi	2 X No		1 ☐ Yes 2 ☑ No			iicaii, e(c.)	Sp	Black, White, ecify:	etc.	
9	hours ural',	d b	3 Nidowed 4 □ Divor		Year or D	ates:	160 Door						White	<u> </u>	
21215-0036	in 72 in 72 in a final contraction of the fina	olete	15. Dece (Specify only hig	hest gra	de completed)		(Giv	edent's Usual Occi e kind of work don DO NOT use retir	e durina mos	t of workin	g	160. Kind	or business/ir	ldustry	
212	d with	mo	Elementary/Secondary (0-1	2)	Cotlege (	1-4or 5+)	Home	emaker				Homer	naker		
פַ	al Hyg	BeC	17. Father's Name (First, Midd	lle, Last)					18. Mothe	er's Name	(First, Middle	, Maiden Sui	mame)		
Maryland	Menta Menta Brked	10	Howard Finzel								Kenzie		•		
Mar	2 sho	1	19a. Informant's Name/Relati	, ,				ling Address (Stree		122 1 27	1.00	er, City or To	wn, State. Zi		
e,	1 and Health 9m 27 ther t	1	Lee Anna Lewis 20a. Method of Disposition		Dau	ighter		Fulmer Road	1	Frede	rick		iryland ion - City or T	21703	
JOL	nt of h	11.1	1 Burial 2 Cremati			State	cemetery, cre	ematory`or other pi	lace)	1434	2005				
Baltimore,	nit. P. artme pritani injury	ı	* 4 □ Donation 5 □ Othe  21. Signature of Funeral Serv			Fi	nzel Cem	etery 22. Name and Add	ress of Facilit		ar-2005	rinzei		Iaryland	
Ba	Depa Impo any ii	9 ,	John ;	R	Ww.	ret	- D	urst Funera	al Home	57 Er	ost Ave	Froeth	ura MI	21532	
			23a. Part. Enter the disease shock, or heart failure.	, or comp	lications that	caused the de	eath. Do not er	nter the mode of dy	ying, such as	cardiac or	respiratory a	rrest,	ruig, IVII	Approximate Interval Betw	reen
	Pnysician		Immediate Cause (Final disease or condition		_	cand	100 1	Allur	5					Onset and D	eath
	/Medical		resulting in death)		Due to	(or as a cons		/							
	Examiner	_	Sequentially list conditions.		b. Dunto	ARTE	The second second	CLEROSI	15				-	15 45	+ns
	led sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	₹	D00 to	(or as a cons	equence or).							-	
	be executed ician and burial-transit	xar	that initiated events resulting in death) Last	1	c. Due to	(or as a cons	sequence of):								
760,	0 0	cal		l	d										
89	leath certificat attending phy I for use as th		IF FEMALE:	252								1			
Вох	ath ce ttendii or use	an/	23b. Was decedent pregnant in the past 12 months?			birth 2 🗆 F	etal death 3	□Ectopic pregnan				23d	. Date of deliv Month	*	ear
o.	0 0 9	Physician/Med	1 □ Yes 2 ⊠ No 9 □ Unknown		4∐Preg 9□Unkn	nant at time o nown	of death 5	Other (specify)						,	
σ.	res that II igned by be detac	'Ph	Part II. Other significant con	ditions o	ontributing to o	leath but not	resulting in the	underlying cause o	given in Part I		23e. Did	tobacco use	contribute to I	he cause of de	ath?
of Vital Records	8 = 0	d by	STROK	3							1 🗆	Yes 2 N	lo 3 ☐ Pro	oably 4 □U	nknown
CO	aw require is been sig 2 should b	Completed	DEPRE	55/	N						24a. Was		4b. Were auto	opsy findings a empletion of ca	vailable
Ä	9 4 9	mo	ANEM									ormed?	death?	2□ No	336 01
ita	icien: Th certificate rector, pag	Be	25. Was case referred to med examiner?							e of Death	(Check only	one)			
) t	S 5	은	1 ☐ Yes 2 ☑ No		_		ER/Outpatie	SIL SLIDON		-			Other (Speci	<i>(y)</i>	
on C	iding Phy Ih. After thi funeral o	lon	27. Manner of Death  1 X Natural 5 □ Pe			of Injury oth, Day Year	28b. Time Injury	W	jury at /ork? □ Yes 2 □		8d. Describe	now injury or	ccurred		
Division	deal deal ctor	fical	3 ☐ Suicide 6 ☐ Co	estigation uld not be ermined	28e, Plac	e of Injury - A	t home, farm, s	treet, factory, offic					umber or Rur	al Route Numb	) <i>01</i> ,
	s after	Certification:	4  Homicide	011111100	build	ling, etc. (Spe	ecify)				City or I o	wn, State)			
	To the Hospitel or Attenwithin 24 hours after deatl To the Funerel Director:  completely filled in by the	edical (						ath occurred at the investigation, in my							
	the hin 24 the F	Medi	one)		and mar	nner stated.									
	1 .		29b. Signature and title of cer		R.	IAn .	$\cap$	7	125	32		1)	M A A	- 6 70	(1 is
•	4		30. Name and address of per	son who	completed care	se of death (	tem 23a) (Type	a. Print)				10	111/1/2	-7, 20	- 0
	1125		George	Bre	za. /	7.10.	912 5	reton K	Dr., C	um	berlan	d, m	0 21	502	
	Sta		31. Date filed (Month, Day, X	ear)	105 32	Registrar's Si	gnature	costs				1		<del>-</del>	
	Regist	rar	MAK 1	# 4	100	10000	- 17								

	_	For State Registrar		of Marylar		artmen rtificate			ind M	F	leg. No.	05	10315
Physicia /Medic		1. Decedent's Name (First, Mide SYBEL	F.		LOE	WING				2. Date of Dea Month March	9 Day 2		4:48P.M
Examin	er	4a. Facility Name (If not institution Suburban Ho	spital			Bet	hes				Мо	nty of Death	ery
Funeral Director		5. Social Security Number 236–36–7657	6. Sex 1 ☐ M 2 <b>X</b> ☐ F	7. Age (In yrs. 76		If Under Months	Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day Sept. 3	1928	9. Birth Cou West	place (State or Foreign ntry) Virginia
Maryland f ehow	lor	Usual Residence of Decedent  10a. State 10b. Count  Maryland Monto	gomery		ty, Town or Lo								10d. Inside City Limits 1 ☐ Yes 2 XNo
with the 1	i Direct	10e. Street and Number 11002 Schuylki	ill Road			10f. Zip	Code 2085	2				of What Cou	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-1 show any Injury or other traumatic event, the Medical Examiner rivet by notified at once.	Completed by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Ma 3 ▼Widowed 4 □ Divorce	Armed 1 ☐ Yes	ecedent Ever in U Forces? s 257No Give X Dates:	1	Was Deced If Yes, spec		ispanic Origin, Mexican	gin? (Spe , Puerto f	cify Yes or No- Rican, etc.)		Race - Ameri Black, White Doify: Wh:	, etc.
21215-0036 ad within 72 hours aft gjene. er than "natural", or the Madical Exam.	mpleted	15. Decede (Specify only high Elementary/Secondary (0-12)	ent's Education nest grade complete College	d) (1-4or 5+)	(Give		rk doné d se retired	ation during most 1) artmei		ng		f Business/Ir	
land 2 Id be filed tental Hygie ked other ic event, I	To Be Co	17. Father's Name (First, Middle Edgar Allen I	e, Last)			<u> </u>	- 01		r's Name	(First, Middle,	Maiden Sun		- La
Maryland and 2 should be file alth and Mental Hy 27 le marked oth er traumatic event	-	19a. Informant's Name/Relation Erick Patterso	nship (Type, Print) ON -SON		19b. Maili 12026	ng Address Belt	(Street a	and Numbe lle Di	rorRum rive	Route Numbe Beltsv:	r, City or To ille,	wn, State, Zi, Maryla	end 20705
Baltimore, permit. Pages 1 ar Department of Hes mportant: If Item any Injury of other page.		20a. Method of Disposition 1  Burial 2 □ Cremation 1  Other		m State NO	Place of Dispo cemetery, cre rbeck	matory or of Memor	iaI P	-	3/	ate /14/200!	5 Olen		ryland
Balti permit. Departr Imports any Inju		21. Signature of Funeral Service	Barewa	eret	$\tilde{I}_{4}^{\tilde{p}}$	20 <b>51</b> p	d Addres Owde	ss of Facility BOTG	ardt I Ro	Fupera ad Belt	l Hom sville	, PA Mar	yland 20705
Pyeo,  And the price of the pri	Ilcal Examiner	23a. Part1. Enter the disease, shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions. Tarry, leading to transcribe cause. Enter Underlying Cause (Disease or injury that infiltated events resulting in death) Last	a. Art Due b. Hyr Due c.	cerioscle to (or as a consec to (or as a consec to (or as a consec to (or as a consec	erotic quence of): on quence of):								Interval Between Onset and Death
ecords, P.O. Box 687 law requires that the death certificate as been signed by the attending phys 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	1 Liv	outcome of pregn e birth 2 Fet: egnant at time of d known	al death 3[	⊒Ectopic pi ⊒ Other (sp					23d.	Date of deliv Month	rery Day Year
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of Vital F Physician: Th ribis certificate ral director, pag	Be	25. Was case referred to medie examiner?	Hospital:				Oth		-	(Check only o	-		
Of Phys r this	on: To	1 ☐ Yes 2 🔀 No  27. Manner of Death 1 🛣 Natural 5 ☐ Peni	28a. Da	□ Inpatient 2 ☐ te of Injury lonth, Day Year)	ZER/Outpatie 28b. Time of fnjury	of 2	28c. Injun Worl	y at k?	2	ne 5 Resid 28d. Describe h			·(v)
ivision at the control of the death of the charles on by the	Certification;	3 Suicide 6 □ Cou	mined 288, Pla	ace of fnjury - At h ilding, etc. (Speci	nome, farm, st	M reet, factor		Yes 2□		28f. Location (S City or Tox		umber or Rur	al Route Number,
To the Hospital or within 24 hours afte To the Funeral Dir. completely filled in i	edical C		ying Physician: To al Examiner: On the and m										
To the Withir comp	Me	29b. Signature and title of continuous	<b>\( \)</b>	- M!	7	290		e number 3200				gned ( <i>Month</i> , 2	
		30. Name and address of personal Alec Anders, I					e, #0	606 Ke	ensir	ngton, N	Maryla	nd 208	395
Sta Registr		31. Date filed (Month, Day, Yes MAR 11	2005	Registrar's Sign	A Apa	de la							

		1	For State	State 0	of Maryland / [		tificate of l			200	1	10216
			Registrar  1. Decedent's Name (First, Middle	(ast)		Cer	uncate or i	Jean	2. Date of De	Reg. No 🛴 📗 ( ath	J J	3. Time of Death
	Physici	_	Hazel Louise		ain				March	7 200	Year 15	9:40 AM
	/Medic		4a. Facility Name (If not institution,				4b. City, Town, or	Location of Deat		4c. County		J.40 AM
	Examin	er	218 Roland Av				Hager	etown		Wasi	ni nat	on County
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. last bir	rthday)	It Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		th v Year)	9. Birthpla	ace (State or Foreign
	Director		212-24-3023	1 □ M 2 <b>X</b> F	78	Yrs.	Months Days	Hours Will.		10 1926		yland
	pc ,		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow	m or Lo	cation				10	d. Inside City Limits
	show	_	10a. State 10b. County		100. Oily, 104	11101 20	Cation					1√2 Yes 2 □ No
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	with t		10e. Street and Number									,
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10	within 72 hours after death with the Maryland ene. than "natural", or Itams 23e or 28e-f show he Medical Evair are must be notified at	Funeral	1 Never Married 2 Marri	Armed Fo	orces?		Yes, specify Cuba	in, Mexican, Puer	to Rican, etc.)	Blac	k, White, e	
336	al', or	by	3 Widowed 4 Divorced	If Yes, Gir Year or D	ve **	1	☐ Yes 2XX No	Specify:		Specify	Whi	te
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pu	12 should be filed within 72 hours after death with the Marylan n and Mental Hygiene. I Ia marked other than "natural", or Itams 23e or 28e-f show reumatic event, the Medical Exami, we must be notified at	Be (	17. Father's Name (First, Middle, I							, Maiden Sumam	•	
yla	Meni Meni arke	J.	Austin Delau							Delaute		
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	and lealth m 27		Linda L. Thom	nas (daug			Old For	де ка. н	agerstow	n Maryla 20c. Location -		
Ore	ges 1 t of F If ita		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 Removal from	State cemete	ery, cren	natory`or other plac					
Baltimore,	tmen tant:		`4 Donation 5 DOther (S)		Rose	- 1	.1 Cemete:		10 2005	nagerst	OWI1	Maryland
Bal	permit. Pages 1 and 2 Department of Health a Important: If itam 27 Is any injury or other tra <u>2005</u> 9.		21. Signature of Funeral Service	N. Fil	111	13	31 Faste	D rn Blyd.	N. Hage	rstown		ral Home and 21742
	.*		23a. Part1. Enter the disease, or shock, or hear failure. List	complications that	caused the death. Do each line.	not ent	er the mode of dyin	ng, such as cardia	c or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	_	Non		odgki				4	Onser and Death  ALONA
J	/Medical		resulting in death)	Due to	(or as a consequence	of):	05,4,50	· · · · · ·				100
н	Examiner		Sequentially list conditions	b								
	ם ד	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a consequence	of):						
	and and I-trans	Examiner	that initiated events resulting in death) Last	C	(or as a consequence	of):						
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8760	physi the t	dlcal		d								
9 ×	death certific attending p	/Me	IF FEMALE:									
Вох	atten for u	an		23c. if yes, ou	itcome of pregnancy					23d Dat	e ot delive	nv.
ci	D 0 D	0	23b. Was decedent pregnant in the past 12 months?	1 Live	utcome of pregnancy birth 2  Fetal death		Ectopic pregnancy Other (specify)	/		23d. Dat Mo	e ot delive	ry Day Year
$\mathbf{C}$	et E	yslcl		1 Live	birth 2 Tetal death		Ectopic pregnancy	9				•
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

				State of M	aryland /	-	rtment of H			ental Hy	giene	0 -	
			- State Registrar			Cen	tificate of L	Death		ı	Reg. No.	005	10317
	Physicia		1. Decedent's Name (First, Middle, Last)	MAR	ood	,				2. Date of Dea Month	Day.	Year 05	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give stre	et and number)			4b. City, Town, or	Location o	of Death		4c. Cou	nty of Death	
	E A GITTIII	<b>.</b>	Peninsula leginon	1 Nedic	of Cen	4-	Salis	hird	,		W	icomi	10
	Funeral		5. Social Security Number 6. Sex	2× 7. Ag	ge (In yrs. last b		If Under 1 Year Months Days	If Under 2 Hours		8. Date of Birt 8-22-1	h		ace (State or Foreign
	Director		222-24-3101 Usual Residence of Decedent	261 00	J 	Yrs.				8-22-1	938		N.C.
	land w		10a. State 10b. County		10c. City, To	wn or Loc	ation					10	Od. Inside City Limits
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336	urs aft	by F	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2X☐ If Yes, Give Year or Dates:	INO	1	☐ Yes 2X No	Specify:			Spe	eify: Wh:	ite
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218	ithin 7	Completed	(Specify only highest grade c	College (1-4or	5+)		ind of work done of O NOT use retired,	)	OF WORKING	g			
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anc	d be find he of	) Be	Bassel B. Holloway							ge Hol		ame)	
Maryland 21215-0036	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. It has the and Mental Hygiene item 27 is marked other then "naturel", or Items 23e or 28e-f show other treumatic event, If a Modical Exercities and the mailing at	10	19a. Informant's Name/Relationship (Type,	Print)	19	9b. Mailing	Address (Street a					m, State, Zip	Code)
ĭS .	alth al 27 is r treu		James R. Libengood	, Husbar	nd 20	01 E	East St	. Del	Lmar,	Md. 2	1875		
Baltimore,	ges 1 and 2 should be filed within 72 hours after death with the Marylan at of Health and Menth Hygiens. If item 27 is marked other then "naturel", or Items 23e or 28e-f show it it item 27 is marked other then "naturel", or Items 21 is marked on the Marient Examilies.		20a. Method of Disposition  X□ Burial 2 □ Cremation 3 □ Rem	aval from State	20b. Place cemet	of Dispos tery, crem	ition (Name of atory or other place	9)	Da	ate	20c. Locatio	n - City or To	wn, State
Ĕ	Pag ment ent: I		`4 □ Donation 5 □ Other (Specify)	ovar nom State	Mary		Veterans			4-05	Hurlo	ck, Md	
3alt	permit. Pages 1 Department of H Importent: If ite eny injury or ot		21. Signature of Funeral Service Licensee			22.	Name and Address Short Fu	s of Facility	Hom	e			
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			shock, or heart failure. List only one	cause on each I	ine.	o not onto		g, 3001 a3 t	cardiac or	163pilatory at	1631,		Interval Between Onset and Death
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-24 0,	and trans	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to fer a	There	=c 4	acre	Red	us .	disea	rl		com
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ج ش	requires that the death certifi een signed by the attending nould be detached for use as	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No		2 ☐ Fetal dea It time of death		Ectopic pregnancy Other <i>(specify)</i>				'	Month	Day Year
P.0	at the	hys	9 Unknown										
Srond	ires that the signed by detaction	by	Part II. Other significant conditions contri	outing to death t	out not resulting	in the un	derlying cause give	n in Part I.			ibacco use co ′es 2 □ No		e cause of death?
Becords,	w requir	Completed	(ancer of	17	unon	1				-		-	
Jec -	The law ate has b	mpl	/							24a. Was autop		prior to con death?	osy findings available apletion of cause of
		е Со	25. Was case referred to medical					00 Floor	of Dooth	1 ☐ Yes	28 No	1 Yes	2 No
35	Prysicien: this certific ral director,	o Be	examiner?	pital:	ent 2□ER/0	Outpatient	31900A Othe			<i>(Check only o</i> e 5 ☐ Resid		ther (Specify	•)
520	F F F	n: I	27. Manner of Death	28a. Date of Inju (Month, Da	ury 28b	. Time of Injury	28c. Injury Work	at		8d. Describe h			/
2 0	Attending r death. sctcr: After by the fune	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		, .,	,,		res 2□N	No				
188N	or Att	ertification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of In building, e	jury - At home, tc. (Specify)	farm, stre	et, factory, office		28	Bf. Location (S City or Tox		nber or Rurai	Route Number,
1	pitel ours a erel [	0	29a. Certifier 1 Certifying Physic	ian: To the hest	of my knowled	ge death	occurred at the tim	e date and	d place, as	ad due to the	Pauco(c) and	mannar ac et	atod
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	edical	(Check only 2 Medical Examiner one)	· On the books	of avamination	andles in.	antination in mu or	inion doot	th againer	d as she sime.			the seven(a)
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Me	29b. Signature and title of certifier	) /-			29c. License	number			29d. Date sign	ndd (Month, L	Day, Year)
	03	1	MayOnda	art:	m		D 6	019	28	9	3/	9/0	5
	5		30. Name and ress of person who comp	pleted cause of	death (Item 23a	(Type, F	rint)	1 -			CIT	64.0	21000
	)		31. Date filed (Month, Day, Year)	32 R. 800	rar's Signature	131	S Sough	- DIV	(15/47	- JV	salish	my mo	Day, Year)  3  3180 4
	Sta Registr		MAR 1 4 200	05	ew d	1 16	back						

OS			For State Registrar		S	State of I	Maryland		artment <i>rtificate</i>			and M	ental Hy	gien Reg. N	20	05	10	3 1 8
		. 1	1. Decedent's Name	(First, Middl	le, Last)								2. Date of De	ath		Vand	3. Time of	Death
	Physici /Medio		Clide		Coo	lige	My	ers				ì	March 2	1,	<b>2</b> 005	Year	2338	рм
	Examir		4a. Facility Name (II			et and numb	er)		4b. City, To			of Death		4	c. County			
			13807 Mye		-	7	Ann fla In	a 4 h inth da	Cumber 1		and If Under:	24 Hes 1	0.00		A.I	lega.		
	Funeral Director		5. Social Security N		6. Sex 1√2 M	2□F /.	Age (In yrs. la	st birthday) Yrs.		Days	Hours	Min.	8. Date of Bir (Month, Di Jan 24	th ly, Yea. <b>1 C</b>	28	9. Birthp	lace (State o	or Foreign
			216-22-5 Usual Residence of										Jan 24	, 15	120	- 10	עווי	
	ehow		10a. State	10b. County			10c. City,	Town or Li								1	0d. Inside C	•
	Ba-f e	cto	MD	Alle	gany			Cumi	perland	1							1½ Yes	2 No
	vith th	<b>Funeral Director</b>	10e. Street and Nun						10f. Zip C					10g. C	itizen of W		try?	
	s 23s	eral	13807 M	yers Av			ent Ever in U.S	140			1502				US			
10	ter de	-un-	11. Marital Status 1 □ Never Marri	ad <b>X</b> ∃Mar		Armed Force	s?	. 13.	If Yes, specif	fy Cubar	n, Mexican	gin? (Spe i, Puerto l	cify Yes or No Rican, etc.)	)•		k, White,	an Indian, etc.	
036	urs al	þ	3 D Widowed			1. Yes 2 ItXes, Give Year or Date	s: WW II		1 □ Yes 2	No No	Specify:				Specify:	white	<del>.</del>	
2-0	72 ho	eted	(Saec	15. Deceden				16a. Dece	dent's Usual kind of work	Occupa done d	tion	t of worki	20	16b.	Kind of Bu			
21215-0036	within 72 hours after death with the Maryland ane. than "natural", or Itams 23a or 28a-f ehow the Madical Examitant is use the invititied at	Completed	Elementary/Secon			College (1-4		iite.	DO NOT use	retired)	)	or worm	·g					
	filled v Hygie othar t	e Co	17. Father's Name (	Eirst Middle	l ast)		<u> </u>	<u>Electri</u>	cian		18 Mothe	r's Nama	(First, Middle				<u>rtation</u>	
Maryland	d tal	To Be	· ·	Oliver		rs							. (Crab			•		
ary	should ind Men s marke umatic	۲	19a. Informant's Na					19b. Maili	ng Address (	(Street a			l Route Numb				Code)	
	1 and 2 Health a tam 27 is		Emelia N	/lyers		wife	)		07 Mye				Cuml				2150	2
J.e.	of He of He litam		20a. Method of Disp		2 🗆 🗆 🗆	aval from Cta	1 001	ace of Disponentery, cre	osition (Name	e of her place	9)	D	ate	20c.	Location -	City or To	wn, State	
Ĕ	Pages ment of I ant: If its ury or o		' 4 □ Donation			ioval from Sta	Suns	et Mer	norial Pa	ark		3	3/25/2005	Cı	umbei	rland	M	ID
Baltimore,	permit. Pages 1 and in Department of Health Important: If itam 27 any injury or othar trange.		21. Signatore of Fu	neral Service,	Licensee	21	MA	r 2	2. Name and Scal	rpelli	s of Facilit Funer	al Ho	me, PA		ء طفاء ا	4500		
			23a. Part1. Enter the shock or hear	ne disease, or	r complicat	tions that cau	sed the death.	Do not en	108 ter the mode	VIrgi of dying	I <b>nia Av</b> g, such as	enue: cardiac o	Cumbe r respiratory a	riano rrest,	I, MD-2	21502	Approximat	θ
	Physician		Immediate Cause (	Final	Only One (		RIENS		Ands	POI	015	0 - 7-1		41110	. 0 10	0 4 4 4 4	Interval Bet Onset and I	
	/Medical-		resulting in death)		a		as a conseque		Alvee		JULE !	2011	c a	2156	EA CO	CECY	R	
	Examiner		Sequentially list cor	nditions.	b. =													
	ed isit	ine	n any, leading to im cause. Enter Unde Cause (Disease or	imediate rlying -	2	Due to (or	as a conseque	ance of):										
•	xecut and	Examiner	that initiated events resulting in death) L		c	Due to (or	as a conseque	ence of):										
8760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the buriat-transit	dical E																
9	tificat g phy as the	a a		<u> </u>	- J													
Вох	eath certific attending p	an/N	IF FEMALE: 23b. Was decedent		23c.		me of pregnan		⊒Ectopic pre	ananev						of delive	ry	
	e dea the att	Physician/M	in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown				t at time of dea		Other (spec						Mon	ith	Day '	/ear
P.0	that the de led by the a detached i		Part II. Other signif	icant conditi	one contril	buting to doot	h but not rocul	ting in the t	odochina an		a ia Dant I		OSo Did	abaaaa		husa sa sh	e cause of d	1450
Records,	ires tha signed I d be det	d by	r un n. other signi	Tourit Goriani	Ona contin	builing to deat	11 001 1101 16381	ung in uie t	indenying cat	ase give	minirani.				_	3 Prob		Jnknown
Ö	w requir been si should	Completed																
Re	The lav	m c					<del></del>						24a. Was auto perfe		d	eath?	osy findings npletion of c	ause of
Vital	ılcian: Th certificate rector, pag	O	25. Was case refer	red to medica	uł T						26 Place	of Death	(Check only	2 N	0 1,	Yes	2□ No	
Ξ	ye s	To B	examiner? 1X Yes 2□		_	pital: 1 □ Inp	atient 2 E	R/Outpatie	nt 3 DOA	Othe	_		ne 5□Resi		6 NOthe	r (Specify	at so	ene
n of			27. Manner of Death	h 5 □ Pendir		28a. Date of I (Month,	Injury Day Year)	28b. Time o	_	c. Injury Work			28d. Describe				rae be	CIIC
Sio	ttendir death. ctor: Al	catic	2 Accident		igation				М		′es 2 🗆 i	No						
Division	or Attending after death. Diractor: After in by the fune	Certification:	3 ☐ Suicide 4 ☐ Homicide	detem	nined	28e. Place of building,	Injury - At hon , etc. (Specify)	ne, farm, st	reet, factory,	office		2	28f. Location ( City or To	Street a wn, Sta	and Numbe te)	r or Rura	Route Num	ber,
	spital ours a neral filled		29a. Certifier	1 ☐ Certifvii	na Physic	ian: To the be	est of my know	rledge, deat	h occurred at	t the tim	e date an	d place, a	and due to the	cansol	e) and mar	nor ac et	ated	
	To the Hospital or Attent within 24 hours after death To tha Funeral Diractor: completely filled in by the	Medical	(Check only one)	2 Medical	Examiner	r: On the basi and manner	s of examination	on and/or in	vestigation, i	in my op	inion, deal	th occurre	ed at the time,	date ar	nd place, a	nd due to	the cause(s	)
	with To t	Σ	29b. Signature and	title of certifie	er *				29c.	License	number MF.				ate signed ch 22			
			Mue	rc										riai.		, 20		
(	09		30. Name and addr	ess of person	WB 1	oleted cause	_	23a) (Type,	Print) 111	l Pe	nn St	reet	Balt	imoı	ce, M	ary1a	and 21	201
	Sta Regist		31. Date filed (Mon	th, Day, Year, MAR 2		32. eg	istrar's Signatu	K A	medi									
						-604	- T. C.											

010	07		1 - State Unpend Item Registrar	State of 1	laryland ,27 pe	d/Depa	artment o	t Hea 28 <u>-</u> 0 of De	alth ar 15 ta eath	nd Mental I	Hygier Reg. N	e .20	05	10	319
	Physici /Medic		1. Decedent's Name (First, Middle, La Warren	Quintin	M	lacka:	11	_		2. Date of Month Marcl		ay 2005	Year	3. Time o	
	Examir		4a. Facility Name (If not institution, give Calvert Memorial	Hospital			4b. City, Tow Prince	e Fre	eder:	ick		c. County	ert C	ounty	
	Funeral Director			Sex 7. / 1 ☑ M 2 ☐ F	45	ast birthday) Yrs.	If Under 1 Y Months Da		Under 24 lours	Min. 8. Date of (Month) Feb.	$\overset{\text{Birth}}{D_{ay}}, \overset{Y_{\text{ea}}}{1}$	960	9. Birth	place (State oftry) I and	or Foreign
- )	death with the Maryland rms 23s or 28s-f show r mast be nettlied at	ector	10a. State 10b. County Maryland Calv	rert		Princ	ce Fre		ick						ity Limits
	23a or 2	Funeral Director	280 Shore Acre	es Way #	147		10f. Zip Co	206	78		10g. C	USA		ntry?	
920	after or Ite		11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceder Armed Force 1  Yes 2 If Yes, Give Year or Dates	xNo		Was Decedent If Yes, specify ( 1 ☐ Yes 2 🚻		nic Origir dexican, f <i>pecify:</i>	n? (Specify Yes of Puerto Rican, etc.)	No-	Blac	e - Americk, White,		
Maryland 21215-0036	"nai	Completed by	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)		r 5+)	(Give life.	dent's Usual Or kind of work do DO NOT use re Inicat	one durin etired)	ng most o	f working spatches	S	Kind of Bu		<sub>dustry</sub> )epar	tment
and	d be filed ental Hyg ced othe c event,	To Be C	17. Father's Name (First, Middle, Last Estep	*	acka1	.1			Mother's	Name (First, Mic	dle, Maide		-	kins	
Mary	iges 1 and 2 should be filed within it of Health and Mental Hygiene. If item 27 Is marked other than " or other traumatic event, Ir a Mark	ř	19a. Informant's Name/Relationship Hilda Mackall/	<sub>(Туре, Print)</sub> Mother		19b. Mailii 6060	ng Address <i>(St</i>	reet and i	Number Rei	or Rural Route Nu	mber, City	or Town,	State, Zip	Code)	20639
Baltimore,	Pages 1 ar nent of Hea int: If item 3 iry or other		20a. Method of Disposition  1 X Burial 2 Cremation 3 ( 4 Donation 5 Other (Special Control of Contr		- CE	emetery, crei	esition (Name of matory or other emeter	place)	3/	Date 12/2005		Location -	•		
Balti	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service Lice  Mladys Q.	Sewel	1	1 <sup>22</sup> P 1	Name and A 51 Da ince	ddress of res Fred	Facility Bea deri	Sewell ch Rd ck, MD	Fund 206	eral 78	Hom	ıe	
	Priysician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events	a. <b>Hyperte</b> Due to (or a	line.	Cardic uence of):					,			Approxima Interval Be Onset and	ween
ox 68760,	death certificate be executed e attending physician and d for use as the burial-transit	dicai	IF FEMALE:	d. 23c. If yes, outcon	as a consequate	ncy						23d Dat	e of delive	arv	
.O. Box	that the death ed by the atter detached for L	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 ☐ Fetal at time of de	death 3[	Ectopic pregn Other (specif)				-	Moi		*	Year
rds, P	w requires that been signed b should be deta		Part II. Other significant conditions  Diabetes mellitu		but not resu	ulting in the u	nderlying cause	e given in	Part I.		id tobacco	_	ribute to th 3 ☐ Prob	ne cause of c	death? Jnknown
Vital Records,	The la ate has page 2	Completed by								24a. V a p 11X Ye	utopsy arformed?	0	leath?	psy findings mpletion of d 2 No	available ause of
Vita	Physician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner?  1 X Yes 2 \sum No	Hospital:	tient 2 🔯	ER/Outpatier	nt 3 DOA	Othor		Death (Check or		6 ∏Oth	er (Specif	v)	
Division of	ffer Inel	Certification: T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Ir (Month, I	njury Day Year)	28b. Time o Injury	28c.	Injury at Work? 1 ☐ Yes	2 🗆 No	28d. Descri	be how inj	ury occurr	ed		
Divi	Ital or Al rs after al Directed in by	Certif	4 Homicide determined	28e. Place or building,	etc. (Specify	me, tarm, str	eet, factory, off	rice			Town, Sta		er or Hura	l Route Num	iber,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the ft	edicai	29a. Certifier (Check only one) 1 ☐ Certifying P	hysicien: To the be miner: On the basis and manner	of examinat	wledge, deat ion and/or in	h occurred at the vestigation, in r	ne time, d my opinio	date and p on, death	place, and due to occurred at the tir	the cause( ne, date a	s) and ma nd place, a	nner as s	tated. the cause(s	:)
	To the within To the Comp	Me	29b. Signature and title of certifier	allan	wd		29c. Lic	OCME				ate signed Iarch		Day, Year) 2005	
			30. Name and address of person who	completed cause of	death (Item	23а) (Туре,		Penn	n Str	eet Bal	timo	ce, M	aryla	and 21	201
	Sta Registi	- 20	31. Date filed (Month, Day, Year) MAR 1 0 2005	32. Regi	strar's Signal	document of the second	,						•		

				State of Maryland / Depa				
			1 - For State Registrar		rtificate of Death		No2005 1032	n
			Decedent's Name (First, Middle, Last)		initiatio of Boatif	2. Date of Death	3. Time of Deal	<u> </u>
	Physici		Betty Jane McKenna	2		March 10	Day 2005 8:05 P	М
	/Medic Examir		4a. Facility Name (If not institution, give st		4b. City, Town, or Location of Deat		4c. County of Deeth	
В			4225 Southwinds Di	rive - Apt. 223	White Plains		Charles	
	Funeral Director		5. Social Security Number 6. Sex 1 □	M 201 F 7. Age (In yrs. last birthday) 68 Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min.	(Month, Day, Ye	9. Birthplace (State or For Country) 1936 Washington DC	eign
	and		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	ocation		10d. Inside City Lin	nits
	e Maryl	Director	Maryland Charles	White Pla	ins		1 □Yes 🌡 □	No
	with th	Dire	10e. Street and Number 4225 Southwinds Dr	ivo Ant 222	10f. Zip Code 20695	10g.	Citizen of What Country?  USA	
	leath	Funeral				Specify Yes or No-	14. Race - American Indian,	
920	be filed within 72 hours after death with the Maryland ital Hygiene. od other then "natural", or Iteme 23a or 28a-f show event, the Medical Exercitrer mast be rediffed at	þ	1 Never Married 2 Marned 3 Widowed 4 Divorced	1 □Yes 2 N No	Was Decedent of Hispanic Origin? (5 If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ☑ No Specify:	to Rican, etc.)	Black, White, etc.  Specify: White	
2-0	72 ho	eted	15. Decedent's Educ (Specify only highest grade	ation 16a. Decer	dent's Usual Occupation kind of work done during most of wo	rkina 16t	. Kind of Business/Industry	
Baltimore, Maryland 21215-0036	within ane. Then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	oo NOT use retired) strative Technic	D	ept. of Justice	
d 2	should be filed within and Mental Hygiene. marked other then metic event, the Mental Men		12 17. Father's Name (First, Middle, Last)	- Adii III i		me (First, Middle, Mai	den Surname)	
lan	ic eve	To Be	John Francis McKenr	na	Hele	n A. Wille	tt	
ary	2 should and Men is marke	-	19a. Informant's Name/Relationship (Typ	e, Print) 19b. Mailir	ng Address (Street and Number or R	ural Route Number, Ci	ity or Town, State, Zip Code)	
Σ,	1 and 2 Health:		James R. McKenna -		Kent Drive, Char			
Ore	permit. Peges 1 and 2 should Department of Health and Men Important: If item 27 is marke eny injury or other traumatic Once.		20a. Method of Disposition 1 ☐ Burial 2 🂢 Cremation 3 ☐ Re	moval from State	natory or other place)		Location - City or Town, State	
睛	artmer artmer ortant injury		*4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Ligenser	Huntt Cr		-2005 Wa	ldorf, MD	_
Ba	Depa Impo eny is		Nack A. Will	° M01246 H <sup>22</sup>	ntt Funeral Home 0. Box 156, Wale	dorf MD 20	0604-0156	
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the death. Do not enter cause on each line.			Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition		2 CAN	CER	Onset and Death	1
4	/Medical Examiner		resulting in death)	Due to (or as a consequence of):				
		ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of):				
	te be executed ysicien and ie burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events					
760,	be executed icien and burial-transit		resulting in death) Last	Due to (or as a consequence of):				
6876	cate b physic the b	dical	d.					
9 x	leath certificate t attending physic I for use as the b	/Me	IF FEMALE: 23	c. If yes, outcome of pregnancy		701	23d. Date of delivery	
.O. Box	0 0 0	Physician/Medi	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown		Ectopic pregnancy Other (specify)		Month Day Year	
S, P	is that the gned by the	by Pt	Part II. Dther significant conditions cont	ributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobace	co use contribute to the cause of death?	?
ord	iw requires theirs been signed to should be det	ted				1 🗆 Yes	2 No 3 Probably 4 Unkno	wn
Vital Record	(a) == (A	Completed				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause	of of
alF						performed 1 ☐ Yes 2 🔀		
Ħ	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner?  1 Yes 2 Ho	ospital: 1 Inpatient 2 ER/Outpatier	Othor	ath (Check only one)	a 6 ☐Other (Specify)	
of	g Phys er this eral di	n: To	27. Manner of Death	28a. Date of Injury 28b. Time of	28c. Injury at	28d. Describe how in		
ion	Attending r death. sctor: After by the fune	atio	1 Accident 5 Pending investigation	(Month, Day Year) Injury	Work? M 1 ☐ Yes 2 ☐ No			
Division	- 2.5 -	Certification:	3 Sticide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, late)	
	To the Hospital o within 24 hours at To the Funerel Completely filled in	edical	29a. Certifier (Check only one)  2 Medical Examin	cian: To the best of my knowledge, deather: On the basis of examination and/or in and manner stated.	n occurred at the time, date and place vestigation, in my opinion, death occu	, and due to the cause irred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)	
	To th withir To th comp	Me	29b. Signature and title of certifier	1 1 1 00	29c. License number	29d.	Date signed (Month, Day, Year)	
,			Koryl	Matt.	~ D 2 & 3	552	3/11/05	
4	BX		30. Name and address of person who con	npleted cause of death (Item 23a) (Type,	Print) Lepla	ta M	0 20646	
	Sta Registr		31. Date filed (Month, Day, Year)  MAR 1 4 21	32. Registrar's Signature	And a		<u> </u>	
	necisi	CIU.	MIAT 14 /	111.1 F. ACMEDIATE A	PERSONAL A			

			1 - For State Registrar	State of Mary		artment of He <i>rtificate of D</i>			iene 2005	1032
	° Physic /Medi		1. Decedent's Name (First, Middle, Last Da Suna	Mercoa	la			2. Date of Death Month MARCH		3. Time of Death  1837 M
The state of the s	Examii Funeral Director		213-14-7423	ral Medical	n yrs. last birthday, 93 Yrs.		ocation of Death  Out of  If Under 24 Hrs.  Hours Min.	8. Date of Birth (Month, Day, June 11	4c. County of Deat  Willow  9. Birt  Year)  1911 MD	
	Maryland -f show	tor	Usual Residence of Decedent  10a. State 10b. County  MD Worces		c. City, Town or L Ocean (					10d. Inside City Limits 1 ☐ Yes 2 🏋 No
	h with the 23e or 28e	ai Direc	10e. Street and Number 21842 Ocean Gatew	ay		10f. Zip Code 21842	<u> </u>	10	Og. Citizen of What Co USA	untry?
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importents if item 27 is marked other then "netural", or Items 23e or 28e-f show ship injury or other treumetic event, The Medical Examiner must be notified at ADDE.	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☒ Divorced	12. Was Decedent Ever Armed Forces? 1  Yes 2 No If Yes, Give Year or Dates:	1	Was Decedent of Hisp If Yes, specify Cuban, 1 ☐ Yes 2 ANO	eanic Origin? (Spe Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	
21215-0036	filed within 72 ho Hyglane. other then "netur ent, the Medical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 11	cation le completed) College (1-4or 5+)	(Give	dent's Usual Occupation kind of work done dur DO NOT use retired)	on ing most of work	ing	16b. Kind of Business	ndustry
Maryland 2	should be filed nd Mental Hygid marked other umetic avent, I	To Be C	17. Father's Name (First, Middle, Last) Harry Clark			11	B. Mother's Name	e (First, Middle, M	faiden Sumame)	
	ss 1 and 2 sho of Health and item 27 is ma other treume		19a. Informant's Name/Relationship (T) Joanne Pruitt/Pers	. Rep.	12419	W. Torqua			City or Town, State, Zity, MD 21	
Baltimore,	permit. Pages 1 Department of H Importent: If ites any injury or ott		20a. Method of Disposition  1 XBurial 2 Cremation 3 F  4 Donation 5 Other (Specify)	Tomovar mom diate	ob. Place of Dispo cemetery, crea St. Paul'	osition (Name of matory or other place) s Cemetery			Chesterto	
Ball	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Licens	felia						Home, p.A.
	Physician /Medical Examiner		23a. Part1. Enter the disease, of complished, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	idations that caused the ne cause on each line.  A. Due to (or as a co	e Trov		such as cardiac c	r respiratory arre	st,	Approximate Interval Between Onset and Death
,8760,	cate be executed physician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co						
.O. Box 6	death certifi e attending id for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	33c. If yes, outcome of pi 1	Fetel death 3	Ectopic pregnancy Other (specify)			23d. Date of deli-	very Day Year
rds, P	The law requires that the ate has been signed by th bage 2 should be detache	by	Part II. Other significant conditions cor	ntributing to death but no	ot resulting in the u	nderlying cause given i	in Part I.	23e. Did toba	acco use contribute to	the cause of death?
al Record		Completed						24a. Was an autopsy perform	prior to c	opsy findings available ompletion of cause of 2 No
	Attending Physicien: Thir death. ector: After this certificate by the funeral director, pag	ation: To Be	25. Was case referred to medical examinar?  1	lospital: 1 Inpatient  28a. Date of Injury (Month, Day Yei 3-09-05	2 PER/Outpatier 28b. Time of Injury	t 3 DOA Other:	4 Nursing Hon	(Check only one ne 5 ☐ Residen 28d. Describe how	oce 6 Other (Special occurred)	ify)
Division	itel or Attend us after death rel Director: /	Certification	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, str becify) SYVC+	eet, factory, office	2	28f. Location (Stree City or Town, PT /S + JE	eet and Number or Rui State) 114 MaCK A	al Route Number OCEAN CM
	To the Hospitel or within 24 hours after To the Funerel Direction completely filled in the formal completely filled in the for	Aedical	one) 21 Medical Exemit	sicien: To the best of my ner: On the basis of exa and manner stated.	knowledge, death mination and/or in	estigation, in my opini	on, death occurre	ed at the time, dat	e and place, and due	to the cause(s)
•	with To	×	29b. Signature and title of certified			29c. License no	1497	290	d. Date signed (Month) $3/11/05$	Day, Year)
			30. Name and address of person who co			Print)   RUI   51.	- 5A	Usbury 1	120	
	Sta Registr		31. Date filed (Month, Day, Year) MAR 1 5	32. Registrar's S	Signature	Contin				

# MacDonald, Charles R.

			Please					artment of h			_		ie.		
	•	For State Registrar					•	rtificate of			Re	g. No. UU	D	10322	
Physic		Decedent's Name (First, Middle, Last)     CHARLES ROBERT MacDONALD					2. Date of Deat Month MAYCh			Day 2005		3. Time of Death 2:50 P M			
/Medi Examii		4a. Facility Name (If not	institution, give	street and	n <i>umber)</i>			4b. City, Town, or Location of Death  CUMBERLAND				4c. County of		īV	
		LIONS MA 5. Social Security Number				)ME (In yrs. last b	irthdav)	If Under 1 Year			8. Date of Birth	ALLE		N I lace (State or Foreign itry)	
Funeral Director		218–10–89 Usual Residence of Dec	35	ÂM 2□F		86	Yrs.	Months Days	Hours	Min.	8. Date of Birth (Month, Day, JAN • 16	,1919 WI	EST_	VIRGINIA	
yland		10a. State 10b	. County			10c. City, To							1	0d. Inside City Limits	
Be-fs	Director	WV	MINE	RAL		RII	OGEI							1 □ Yes 2) No	
with th	Dire	10e. Street and Number	0					10f. Zip Code	- 0		10	og. Citizen of Wh		ntry?	
ns 23	Funerai	11 LYON 11. Marital Status	11 LYON STREET           Marital Status         12. Was Decedent Ever in U.S.         13					2675 Was Decedent of I	gin? (Spe	U . S . A	Americ				
IL FILE 13-0030 filed within 72 hours after death with the Manyland Hygiene. wher then "natural", or items 23a or 28e-1 show ont, the Medicel Ever invertor to rediffice an	by Fun	1 ☐ Never Married 3 🖫 Widowed 4 ☐	_	1 XYe	Forces? es 2 ☐ N Give er Dates:	°wwii		Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - Ai Black, W  1 □ Yes 2 ☒ No Specify: Specify:						etc. HITE	
72 hou		15. (Specify or	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Giv				a. Dece	dent's Usual Occup	t of worki	16b. Kind of Busi	. Kind of Business/Industry				
within in the han "in the han" in the han "in the han "in the han in the han	Completed	Elementary/Secondar			e (1-4or 5-	+)		kind of work done DO NOT use retire	d)		STEEL				
Hygier ther ther		1.7. Father's Name (First	, Middle, Last)					JLIKIK	18. Mothe	er's Name	ame (First, Middle, Maiden Sumame)				
permit. Pages 1 and 2 should be filed within permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 is marked other than any injury or other traumatic event, IL a Magnes.	To Be			acDON	IALD				WA	NDA	LEE	EE CARTER			
and M and M s mar	-	19a. Informant's Name/	Relationship (1	ype, Print)		19		ng Address (Street		er or Rura	l Route Number,				
and and mark		JACK McF		) / E	XECU			O . BOX sition (Name of	87,		GELEY,	WV 26	753		
uges 1 or oth		20a. Method of Dispositi	emation 3 🗆		om State	ceme	ery, cre	matory or other pla							
callification remit. Pages partment of portent: If if y injury or of the		*4 □ Donation 5 □ 21. Signature of Funera				RESTL	2	MEML . GAR 2. Name and Addre	ess of Facilit	ty		LAVALI	5, PI	D .	
Departing Department of the sany in the sany in the sany in the sany in the sany in the sange of		Yours	D. 2	ach	un	0		UPCHURCH 202 GREE					2	1502	
		23a. Part1. Enter the di shock, or heart fai	sease, or com	one cause o	at caused on each lin	the death. De	o not en							Approximate Interval Between Onset and Death	
Physician		Immediate Cause (Fina disease or condition	ı	a. C.O.	rona	y A	ter	y Dise	8 ×				1	c YVS	
/Medical Examiner		resutting in death)	(	Due	to (or as a	consequenc	e of):	4						/	
	ē	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury													
executed executed an and rial-transit	Examiner	cause. Enter Undertying Cause (Disease or injury that initiated events  c.													
rou, e be executed /sician and e burial-transit		resulting in death) Last	ulting in death) Last Due to (or as a consequence of):												
oo/o	dicai		•	d			_								
ath certifi	ician/Medi	IF FEMALE: 23b. Was decedent pre	23c. If yes, outcome of pregnancy								23d. Date	of delive	•		
BCOTGS, P.O. BOX 08/ Iaw requires that the death certificate as been signed by the attending phys should be detached for use as the	ysiciai	in the past 12 mon 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	months?						Month Day Year						
that the hed by	by Physic	Part II. Other significan	1. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  1. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  1. The state of the conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tob	Did tobacco use contribute to the cause of death?					
oquires an sign	ed b	Kenal							s 2 No 3 Probably 4 Unknown						
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Of VITA Physicien: r this certific	Be	25. Was case referred to examiner?	o medical	Hospital:	- Innatio	nt 2[]EB/	Outnatio	nt 3 DOA Ot	10.1		n <i>Check onl</i> on		/Snecif	(v)	
F E E	n; To	27. Manner of Death	27. Manper of Death  28a. Date of Injury  28b. Injury  28b. Injury  28b. Injury  28c. Value of Day York								,,				
SION tending death. tor: Aft the fun	atio	1 Natural 5 Pending investigation 2 Accident 3 Suicide 4 Homicide 4 Homicide (Month, Day Year) Injury Work?  (Month, Day Year) Injury Work?  M 1 Yes 2 No  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)													
Z Z Z Z Z	Certification;								28f. Location (Street and Number or Rural Route Number, City or Town, State)						
spita hours inere	Medicai C	29a. Certifier (Check only one)  29a. Certifier (Check only one)  12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as tared.									ner as st id due to	tated. the cause(s)			
To the Ho within 24 i To the Fu completel	Med	29b. Signature and title	of certifier					29c. Licen	se number			9d. Date signed			
7/104		•	H	y fr	~~				33		$\supset$ /	March	4,	2005	
nks		30. Name and address	of person wo	completed o	cause of d	eath (Item 23)	a) (Type 5 k	ent An	ienu	e (	umbe	rland.	MI	21502	
S	tate	31. Date filed (Month, D		05	Registra	ar's Signature	Lo	ast s							
Regis	trar	MAF	( U / 20	UJ	1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1	4 83	PER								

				State of N	aryland		rtment of t	Health and I Death		JIENE Neg. No. 🥠	005	1000	
	Physicia		Decedent's Name (First, Middle, Last	2. Dete of Dee Month Marc	Dey	Year 2005	3:03 AM						
1	/Medic Examin		4e Fecility Neme (If not institution, give Cumberland Nur.	4b. City, Town, or L		4c. Count	y of Deeth	egany					
	* Funeral Director		214-03-0104	ex 7. Age (In yrs. last bir			If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birth (Month, Day	, Year) 11, 1914	9. Birthpla Countr	ce (Stete or Foreign y) ryland	
	nyland thow		Usuel Residence of Decedent  10e. Stete 10b. County	. 10c. City, Town or Location							10	d. Inside City Limits	
	the Mary	Director	Maryland All  10e. Street end Number	egany ·		-	10f. Zip Code	Cumberla		l0g. Citizen of	Whet Countr	1 Yes 2 No v?	
	ath with	rai Di	10 Nort	h Liberty				21502				SA	
020	within 72 hours after death with the Maryland ene. than "netural", or items 23a or 28a-f show he Madical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Merried  3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces 1 ☐ Yes 2 ☐ If Yes, Give △ Yeer or Detes:	? No	1	fas Decedent of I Yes, specify Cub ☐ Yes 2☐,No	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)		ce - America ick, White, et fy:		
21215-0020	within 72 ho iene. than "natur the Medical	Completed by	15. Decedent's Edu (Specify only highest gred Elementery/Secondary (0-12) 12	cation e completed)  College (1-4or 5+)		(Give k	O NOT use retire	during most of work					
nd	be filed tal Hygi d other	To Be	17. Fether's Neme (First, Middle, Lest)	17. Fether's Neme (First, Middle, Lest)  18. Mother's Nam							ne)	alle	
Maryland	2 should be and Mental is marked c		Edwa	t end Number or Ru	Edith (Johnson)  lumber or Rurel Route Number, City or Town, Stete, Zip Code)								
, K	and 2 leath a m 27 is		Warren A. E. Ma				8148	3 Riverside	e Dr., Pas	sadena,	MD 21	122	
Baltimore,	Pages 1 ment of H ant: if ite lury or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 2 ☐ Other (Specify)	lemoval from State	ice of Dispos metery, cremi ithsbur	Date 3/7/05							
Bail	Departi Departi Importi any in		21. Signature of Funeral Service Licens		Kight Funeral Home St., Cumberland, MD 21502								
1	Physician	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.  Approximately 1710  Appr											
mark.	/Medical Examiner	70	Immediate Cause (Final disease or condition resulting in death)	a. Coronany arten disease 24e								2 years	
X 58760, certificate be executed	icate be executed physician and s the burial-transit	Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury	b									
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C. BOX	a death the atter	Physician/M	Part II. Other significant conditions con	tributing to death b	out not result	derlying cause giv	ven in Part I.	23b. Did to	bacco use co	ntribute to t	he cause of death?		
S, P.O.	is that th gned by se detac	by Ph							1 □ Y	es 2 No	3 🗌 Proba	bly 4 Unknown	
DIVISION OF VITAL RECORDS,	To the Hospital or Attending Physician: The law requiras that the death certiwithin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completally filled in by the funeral director, page 2 should be detached for use so	Completed			24a. Was an autopsy performed? 24b. Were autopsy findin available prior to completion of cause of death?			able prior to eletion of cause					
Ta T	in: The ifficata h		25. Was case referred to medical				· ho	26 Place of Dogs	h (Check only on		10	res 2□ No	
<u> </u>	hysicie this cert al direct	<u> </u>	examiner? 1 Yes 2 No	1	1	R/Outpatient	3□ DOA Oth	ner: 4 Nursing Ho	Place of Death (Check only one)  Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)				
<u> </u>	Attending P ir daath. ector: Atter by the funer	ation	27. Menner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28e. Dete of Injury (Month, Dey Year)   28b. Time of Injury   28c. Injury at Work?   1 □ Yes 2 □ No					28d. Describe how injury occurred				
	tel or Atters after date bill Director ed in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)				
:	Hospi     24 hour     Funer     Idetaly fill		29a. Certifier (Check only one)  1 ** Certifying Phys 2   Medical Examin	iclan o the best er n the basis and manner	t examinatio	edge, death on end/or inve	occurred et the tir stigation, in my o	me, date end place, prinion, death occur	and due to the cared at the time, da	use(s) and ma ate and place,	anner as state and due to th	ed. ne cause(s)	
		¥ -	29b. Signature and title of certifier	29d. Date signed (Month, Day, Year)  MMCH 7, 2004									
•	3		30. Name end eddress of person who co	mpleted cause of c	leeth (Item 2	3e) (Type, Pi		36766		TTTTCE	7 (	1004	
	nds			.nai. N	4. D.	924		Or., Cum	berlan	2150	12		
	Stat Registra		31. Date filed (Worth, Day, Year) 1	4	er's Signetui	re 4 /		,					

DHMH 16 Rev 6/95

			For State Registrer	State of	Marylan	•	artment rtificate			Mental Hy	giene Røg. No.	200	· 11	1001	
1. Decedent's Name (First, Middle, Last)											ath		3. Time	of Death.	
	Physicia		Mary	Eleano	or	McGregor			Month	Day 15.	Year 2005	0710	А М		
	/Medic Examin		4a. Facility Name (If not institution	, give street and num	ber)		4b. City, T	own, or	Location of Dea			County of Deat			
	LXammi	٠.	Cumberland Vil	la Nursin	o Cente	r		Cun	berland			Alleg	anv		
	Funeral		5. Social Security Number		7. Age (In yrs.		If Under 1	Year	If Under 24 Hrs	8. Date of Bir	th Your		hplace (State	or Foreign	
	Director		212-38-5691	1□M 2\\ F	95	Yrs.	Months	Days	Hours Min	02/28/	1910		y land		
-	2		Usual Residence of Decedent												
U Z I Z I 3-UU30 filed within 72 hours after death with the Maryland	ryiar ihow	_	10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside		
2	Ba-f s	cto	MD A	11egany		F	rostb	urg					I MALY E	s 2 No	
5	or 28	Sire	10e. Street and Number				10f. Zip (	Code			10g. Citiz	en of What Co	ountry?		
-	236	Ta	60 Broadway					2153				USA			
4	S He	ne	11. Marital Status 12. Was Decedent Ever Armed Forces?			in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or Nilf Yes, specify Cuban, Mexican, Puerto Rican, etc.)						<ol> <li>Race - Ame Black, White</li> </ol>			
2	orl	by Funeral Director	1 Never Married 2 Marri	If Yes, Give	1 ☐ Yes 2 ☒ No If Yes, Give		1 ☐ Yes 2 ☒ No Specify:					Specify:			
Ś	urel'		3 ₩idowed 4 Divorced	Year or Da	tes:	10- D	danda Harra	0	Al		4.05 161-	White  . Kind of Business/Industry			
2	"net	Completed	15. Decedent (Specify only highes	t grade completed)		(Give	dent's Usual kind of work	done di	uring most of wo	160. Kir	id of Business/	industry			
7	than	E C	Elementary/Secondary (0-12) 1 2	4or 5+)	Teacher						Public Schools				
7 · 7	Hygie ther int, I		17. Father's Name (First, Middle,	Last)			reach		18. Mother's Na	me (First, Middle			3110010		
yland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importment if time 27 is marked other than "neturelt, or Items 23e or 28a-f show any injury or other traumatic event, the Marical Examinating the right of once.	To Be	Nooh Sylvanus Twigg Mary Ed							Edi	ith Simms				
משב	and and is ma		19a. Informant's Name/Relationsh	ship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route					lural Route Numb	er, City or	y or Town, State, Zip Code)				
<u>.</u>	and ealth n 27 er tr		Sue Cerutti /	niece		_			eet, Cuml	perland, M					
ָ עַב	of H of H iter or oth		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation	3 ☐Removal from S		Place of Dispo cemetery, cren	nsition (Name matory or ott	e of her place	)	Date	20c. Loc	cation - City or	Town, State		
	rag ment ent: l		'4 □Donation 5 □Other (S)		Cur				ory  03/1			berland	,		
paltimore,	permit. Departi Import any inj		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Adams Family Fune												
	80 = 20		Kalat C. Pole 404 Decatur Street, Cumberland,										2150	2	
	- 1		23a. Part 1. Enter the disease, or complications that cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between											etween	
F	hysician		Immediate Cause (Final disease or condition resulting in death)  a. Atherosclerotic Cardiovascular Disease  Due to (or as a consequence of):										Onset and 2 ye		
H.	/Medical														
Examiner			Sequentially list conditions.												
п =	o #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C. Due to (or as a consequence of):												
	acute ind trans	am													
Š	ian a urial-	Ě	resulting in death) Last Due to (or as a consequence of):												
00/00,	Projection: The Taw Fequires that the death certificate be executed. This certificate has been signed by the attending physician and rat director, page 2 should be detached for use as the burial-transit	dical													
Ö	ing p	Physician/Med	IF FEMALE:												
ָבָׁבְּבָּבְּבָּבְּבָּבְּבָּבְּבָּבְּבָּבְּבָּבְּבָּבְּבָּבְּבָּבְּבָּבְבָּבְבָּבְּבְּבָבְבָּבְבָּבְבְּבָבְבָּב	ath co	an/	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy								2	23d. Date of delivery  Month Day Year			
5	the a	sic	1 Tyes 2 No 9 Unknown 9 Unknown							22,					
	d by letacl	Ph)								23a Did t	Did tobacco use contribute to the cause of death				
'n	res tres tres tres tres tres tres tres t	by	Part II. Durier significant conditions continuously to death out not resolving at the discontinuous given at Part I.									es 2 No 3 Probably 4 Munknown			
cords,	neen hould	Completed													
ည် - ရ	araw asb	nple									24b. Were autopsy findings available prior to completion of cause of				
= '	ding knyetcien: The lav h. After this certificate has funeral director, page 2	Cor	pend 1 ☐ Yes							ormed? death? 2√ No 1 Yes 2 No					
NICAL NICAL	entifi ector	Be	25. Was case referred to medical examiner?					0		ath (Check only					
5 2	his c	2	1 ☐ Yes 2 📉 No		npatient 2			A Othe	4 Nursing		ne 5 Residence 6 Other (Specify)  8d. Describe how injury occurred				
	Miter	on:	27. Manner of Death 1   Natural 5   Pendin	g 28a. Date of (Month	f Injury n, Day Year)	28b. Time of Injury		Bc. Injury Work		28d. Describe					
S S	el or Attending Pratter death. I Director: After to in by the funera	Certification:	2 Accident investigation						1 ☐ Yes 2 ☐ No			(Corner and Alumber of Dural Courts Alumber			
₹ 3	or At tter c Direct in by	III	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, ets. (Specify) 28f. Location (Str. City or Town,								treet and Number or Rural Route Number, n, State)				
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:	To the Hospitel of Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Medical	29a. Certifier 1 (Check only one)  29a. Certifier 1 (Check only one)  29a. Certifier 1 (Check only one)  29a. Certifier 1 (Check only one)  29a. Certifier 1 (Check only one)  29a. Certifier 1 (Check only one)  29a. Certifier 1 (Check only one)  39a. Certifier 1 (Check only one)  49a. Certifier 1 (Check only one)  49a. Certifier 1 (Check only one)  49a. Certifier 1 (Check only one)  59a. Certifier 1 (Check only one)  69a. Certifier 1										(s)		
;	vithir To th	M	29b. Signature and title of certified	1 /2			29c. License number					29d. Date signed (Month, Day, Year)			
ĺ	8		) /h	Un/				D3	6766		Marc	h 15,	2005		
			30. Name and address of person			n 23a) (Type,	Print)				4 = 0 -				
	MLS		Vik Poo	nai, M.D.,	924	Seton	Drive	, Cu	mberlan	d, MD 2	1502				
	* Sta		31. Date filed (Month, Day, Year)	G 0005 32. Re	strar's Signa	ature	A 14	04							
	<sup>/</sup> Registr	ar	MAR 1	6 2005	Column of the second	St. 65	DANGE	1							

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day OLGA M. V. MILNE MARCH 3, 2005 6:05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Manor Care of Silver Spring Silver Spring MONTGOMERY If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Mar. 28, 1921 9. Birthplace (State or Foreign **Funeral** Days Hours 1 M X F Country) Panama 068-28-3396 83 **Director** Yrs Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, Ite Modical Executer mast be notified at once. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Director Montgomery Silver Spring 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3163 Beaverwood Lane 20906 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2½ No if Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🏖 No Completed by Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+) Airline Security 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Frederick Rose Grace A. Barnes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906 19a. Informant's Name/Relationship (Type, Print) Emile Milne (Son) 3163 Beaverwood Ln, Spring, Silver 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 108urial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Ga > 5 Other (Specify) of Heaven Cem 3/14/05 Silver Spring, MD 21. Signatu duneral Service Lizana 22. Name and Address of Facility Snowden Funeral Home, P.A. <u>2</u>46 N. Wash. St., Rockville, MD 20850 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 4ears disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit attending physician and Due to (or as a consequence of): Box 68760 Physician/Medical thel IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. detached 9 Unknown Other significant/conditions contributing/to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 🗌 Yes 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed2 1 Yes 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 ☐ Yes 2 P 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of After t Certification; 28d. Describe how injury occurred Natural Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation I Director; d in by the f 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Employed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and the of certifier (c ress of person who completed cause of death (Item 23a) (Type, Print) TAPIKONDA 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar 2005

			1 - For State Registrar	•	ryland / Depa		lealth and I	•		2005	10326
			1. Decedent's Name (First, Middle, Las	it)				2. Date of De	eath _ Day	Voor	3. Time of Death
	Physici /Medio		Evelyn Sheffer	Masters				March	6,	2005	5:55P. M
	Examir		4a. Facility Name (If not institution, give		4 D 1 1 G		r Location of Death	1		County of Death	
	,		Hillhaven Assisted Liv			Adelp	hı If Under 24 Hrs.	O Data of Bir		ince Geo	
	Funeral Director		5. Social Security Number 6. S 227–20–5462 1  Usual Residence of Decedent	-x 7. Age □ M 2√Ω F	(In yrs. last birthday) 85 Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da May6,			place (State or Foreign pintry)
	Maryland a-f show	ctor	Maryland Prince C	George's	10c. City, Town or Lo Adelphi	ocation				1	0d. Inside City Limits 1 ☐ Yes 2 XNo
	th with the 23a or 28	ai Dire	3210 Powder Mill	Road		10f. Zip Code	20783			ed State	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items 23a or 28a-f show amount injury guether treumatic event, the Medical Examble multiple multiple of the Apple 1.	by Funer	11. Marital Status  1 ☐ Never Married 2 ☐ Married  2 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑N If Yes, Give Year or Dates:	0	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 X No	lispanic Origin? (S an, Mexican, Puert Specity:	pecify Yes or No o Rican, etc.)		4. Race - Americ Black, White, Specify:	
Maryland 21215-0036	within 72 ho ane. then "natur ne Medical.	mpleted	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5-	(Give	dent's Usual Occup kind of work done of DO NOT use retired	during most of wor d)	king	Prin	od of Business/Inc ce Georg ol Syste	ge's Co.
land 2	uld be filed Aental Hygi rked other tic event, I	To Be Co	17. Father's Name (First, Middle, Last)  Caleb C.	Shei			18. Mother's Nan Martha	ne (First, Middle	-		
Mary	ind 2 shou alth and M 27 is ma or treuma		19a. Informant's Name/Relationship ( Martha J. Robin -		19b. Mailin 20 Co	ng Address (Street Ornwall S	and Number or Ru treet, N	ral Route Numb	er, City or burg	Town, State, Zip , Virgir	o Code) nia 20176
Baltimore,	Pages 1 a ent of He nt: If item ry or ethe		20a. Method of Disposition 1    Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	20b. Place of Disponsional Company Comments of Congress Water Section 20 March 20 Ma			Date 7 3/10/2		ation - City or To	
Balti	permit. Departm Importe any inju		21. Signature of Funeral Service Licen		DX 22	Name and Address Nald V. 100 Powde	ss of Facility Borgwardt r Mill Ro	t Funera	ıl Hor svil	me, PA le. Marv	land 20705
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.O. Box 68	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 【XNo 9 ☐ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at 9 □ Unknown	2 ☐ Fetal death 3 ☐	Ectopic pregnancy			2	3d. Date of delive Month	ery Day Year
<u>α</u>	quires that on signed b uld be deta	by	Part II. Other significant conditions of Diabetes Mellitus				en in Part I.		_	_	ne cause of death?
Il Records,	: The law requir cate has been s page 2 should	Completed						24a. Was auto perfo	psy ormed?	24b. Were auto prior to cor death? 1 \(\sum \) Yes	psy findings available mpletion of cause of 2 No
Vital	ician: Th certiticate ector, pag	Be	25. Was case referred to medical examiner?	Hospital:		Oth	26. Place of Dea				
of	ding Phys n. After this funeral dii	ion: To	1 ☐ Yes 2 🛣 No  27. Manner of Death  1 🛣 Natural 5 ☐ Pending	28a Date of Injur (Month, Day	nt 2 ER/Outpatier y 28b. Time of Year) Injury	f 28c. Injur Wor	y at	ome 5 Resi 28d. Describe		Other (Specify occurred	y)
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	To the Hospitel or At within 24 hours after of To the Funerel Direct completely tilled in by	edical C	29a. Certifier (Check only one)  Certifying Ph 2 Medical Exam	ysician: To the best on niner: On the basis of and manner sta	examination and/or in	n occurred at the tin vestigation, in my o	ne, date and place pinion, death occu	, and due to the rred at the time,	cause(s) a date and	and manner as si place, and due to	tated. the cause(s)
)	To the within 2 To the complet	Me	29b. Signature and Melolycertifier	Buc		29c. Licens D3156				signed (Month, ch 9, 20	
Y	1		30. Name and address of person who Charles M. Benner				205 Silve	r Sprine	g, Ma	ryland 2	20901
	Sta Regist		Charles M. Benner 31. Date filed (Month, Day, Year)  MAR 11 20	05 Scheme	r's Signature	ule				_	

			1- State of Maryland / Department Certificate			2000	1000
			Registrar  1. Decedent's Name (First, Middle, Last)		Reg. te of Death	. No. (_ U U )	3. Time of Death
	Physici		Wayne Howard Michael	Mo	rch 1	Day Year 4 2005	
	/Medic Examir			wn, or Location of Death	LCII	4c. County of Death	6:00AM
-	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1		te of Birth	Washingto	on County place (State or Foreign
	Director		236-72-0234 1X M 2 F 57 Yrs. Months Usual Residence of Decedent	Days Hours Min. (Mo Apr	onth, Day, Yorld 18		Virginia
	nyland how		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	8a-f s	Director	Maryland Washington Hagerstown				1 ☐ Yes 2X No
	with the		10e. Street and Number 10f. Zip C		1	. Citizen of What Cou	,
	ns 23	Funeral	1743 Edgewood Hill Circle Apt. 101  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent	21740		nited Stat	
396	in 72 hours after death with the Maryland "natural", or Items 23a or 28a-1 show solical Examinat must be notified at	by Fun	Amed Forces?   If Yes, specify  1 Never Married   Married   1 Yes   2 No    1 Widowed   Divorced   Yes of Category   1 Yes   2 Yes    2 Vear or Dates:	t of Hispanic Origin? (Specify Ye Cuban, Mexican, Puerto Rican, ] No Specify:	etc.)	Black, White,	
21215-0036	72 hor	sted	15. Decedent's Education 16a. Decedent's Usual ( (Specify only highest grade completed) (Give kind of work	Occupation done during most of working	161	b. Kind of Business/In	ndustry
121	within lene.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	retired)			
12	be filed with tal Hygiene. d other than event, treat		17. Father's Name (First, Middle, Last)	18. Mother's Name (First,	Middle Ma	Carpet Co	mpany
Maryland		To Be	Emil Rau Michael	Mae Hutzl			
lan	and and is m			treet and Number or Rural Route			
	s 1 and 2 if Health item 27 othar tre			wood Hill Circl			
Baltimore,	0 0		20a. Method of Disposition  1 XBurial 2 Cramation 3 Removal from State  1 Donation 5 Other (Specify)  20b. Place of Disposition (Name cemetary, cramatory or othe Rest haven Cemetary)	etery Mar 17 2	005 Ha	c. Location - City or To agerstown	Maryland
Balt	permit. Peg Department Importent: I any Injury o		21. Signature of Funeral Service Licensee 22. Name and 21. Signature of Funeral Service Licensee 22. Name and 22. Name and 23. Signature of Funeral Service Licensee 22. Name and 23. Signature of Funeral Service Licensee	Address of Facility Dougla stern Blvd. N.	s A. H Hagers	Fiery Fune stown Mary	ral Home land 21742
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or hear/failure. List only one cause on each line.				Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	o my opethy	1		Onset and Death
	/Medical Examiner		Due to (or as a consequence of):	not tallen	L		
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	7 40000			
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90,	cate be executed bhysicien and the burial-transit		resulting in death) Last Due to (or as a consequence of):		U		
8760	physic the b	dicai	d				
9 x	eath certific attending p	/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delive	201
.O. Box	0 0 0	Physician/Me	in the past 12 months?  1 Yes 2 No 9 Unknown  1 Live birth 2 Fetal death 3 Ectopic preg 4 Pregnant at time of death 5 Other (speci			Month Month	Day Year
Δ.	es Be	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause Liver Circles with herest	e given in Part I. 23	e. Did tobac	co use contribute to the	
Records,	aw requir as been si 2 should	olete	Chronic atrial Abrillation	J 24	a. Was an	24b. Were auto	ipsy findings available
al Re	The ate h page	Completed	, , , , , , , , , , , , , , , , , , ,	1	autopsy performed Yes 2	prior to co death? No 1 \( \text{Yes}	mpletion of cause of
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?  Hospital:	Other: 4 D Nursing Name 6			
of	Phys or this oral di	.To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c	Injury at 28d. De		<ul> <li>6 ☐Other (Specifing of the second of the sec</li></ul>	y)
ion	Attending I r death. ector: After by the funer	atio	1 ☑ Matural 5 ☐ Pending (Month, Ďaý Year) Injury 2 ☐ Accident investigation M	Work? 1 ☐ Yes 2 ☐ No		. ,	
Division	of or Attendate after death Director:	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, o building, etc. (Specify)	fice 28f. Loc City	ation (Stree or Town, S	t and Number or Rura tate)	al Route Number,
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at a control of the contr	ne time, date and place, and due my opinion, death occurred at the	to the cause e time, date	e(s) and manner as s and place, and due to	tated. the cause(s)
	To th within To th compl	Me		cense number	29d.	Date signed (Month,	Day, Year)
		'ni	Jegg Vin.P. &	0041131	V	uarch 15	12005
33	H-3+1		30. Name and address of purson who completed cause addeath (Item 23a) (Type, Print)	4 Dpul Con	7.1	tagers tow	1,2005
Ĭ	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	1 - 1			21740
	Registr	ar	MAR 17 2005 Deen J. Sperke				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 2 Day Year A.M. Shirley Nelson Paul 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) AlleGAN UMBERIANCE Jer 1 Year | If Under 24 Hrs. red Me Birthplace (State or Foreign Country) If Under 1 Year Date of Birth (Month, Day, Year) Age (In yrs. last birthday) Social Security Number Days Hours Min. 1以M 2□F 84 Mary land 11/04/1920 212-12-8672 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2 ☑ No LaVale **Allegany** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 60 Lavale Boulevard Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc 1 XYes 2 No 1942-If Yes, Give Year or Dates: 1945 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specity: 3 ☐ Widowed 4 ☐ Divorced 1945 White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Construction Electrician 11 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Clara Etta Nelson Francis Robert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 60 LaVale Boulevard, LaVale, Maryland 21502 Myrtle H. Nelson / wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Flintstone, Maryland 03/18/2005 MD Vet. Cem @ Rocky Gap ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Adams Family Funeral Home, P.A. Cide 404 Decatur Street, Cumberland, Maryland 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Due to (or as a consequence of): eAR5 resulting in death) Due to (or as a consequence of): 3 Weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 3 Weeks Meningitis

Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Donknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Pres 2 No 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Impatient 1 Yes 2 1 No 2 ER/Outpatient 3□ DOA 28b Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

The law requires that the death certificate be executed burial-trans Division of Vital Records, P.O. Box 68760, physicien use as the attending p signed by the a peen page 2 has this certificate or Attending Physician: rector, funeral di within 24 hours after death. To the Funerel Director: After completely filled in by the the 2 8

**Physician** 

/Medical

**Examiner** 

Director

Funeral

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Be Completed

**Funeral** 

Director

if item 27 is marked other than "neturel; or items 23a or 28e-f show or other treumstic event, Ire Madical Examiner must be mailied at

and Mental Hygiene.

permit. Pages 1 and 2 should be file Department of Health and Mental Hy, importent: if item 27 is marked othe any injury or other treumatic and

**Physician** /Medical

Examiner

Examiner

Physician/Medical

Completed by

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Certification: To

Medical

with the Maryland

filed withIn 72 hours after death

Baltimore, Maryland 21215-0036

1/23 State Registrar

DHMH 17 Rev 1/2001

completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who ChotANI MADID enns

37 Registrar's Signature 31. Date filed (Month, Day, Year) MAR 1 6 2005

Ave Cumberland MD

			1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of H			ene g. No 20 (	)5 insec
	Physic	ian	Decedent's Name (First, Middle, Last)					2. Date of Death Month		3. Time of Death
	/Medi	cal.		OSEPH	NICHOLS			March 7		09:42 P. <sup>M</sup>
	Exami	ner	4a. Facility Name (If not institution, give stre	et and number)			r Location of Dear	th	4c. County of	Death
	Funeral		St. Agnes Hospital  5. Social Security Number 6. Sex	7. Age	e (In yrs. last birthday)	Baltime If Under 1 Year	Ore If Under 24 Hrs	8. Date of Birth		9 Rithplace /State or Foreign
	Director		214-17-6147 1X M	2 F	24 Yrs.	Months Days	Hours Min		1981	9. Birthplace (State or Foreign Country) Maryland
	pu \star		Usual Residence of Decedent  10a. State 10b. County		10- 01- T I					
	f ehow	ō	MD Howard		10c. City, Town or Lo	ghland				10d. Inside City Limits
	28e-1	Director	10e. Street and Number		111	10f. Zip Code			033	1 No 2 No
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	ter deat	Funerai		Was Decedent B Armed Forces?	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba		Specify Yes or No-	14. Race -	American Indian,
98	a o		1 Never Married 2 Married	1 Yes 2 XN	10	fYes, specify Cuba 1 □ Yes 2-2 No	an, Mexican, Puer Specify:	to Rican, etc.)		White, etc.
21215-0036	72 hours after "netural", or Ite	d by	3 Widowed 4 Divorced	Year or Dates:					Specify:	Black
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	e filec al Hyg othe vant,	BeC	17. Father's Name (First, Middle, Last)			110111111111111111111111111111111111111		me (First, Middle, Ma		
<u>Ial</u>	Ments Ments arked	ToE	George L. Nich	olson			Che	eryl Har	ding	
Maryland	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If itam 27 is marked other then "netur any injury genthar traumatic event, the Medical DOCE.		19a. Informant's Name/Relationship (Type,	•				ural Route Number,		
	l and lealth m 27 har tr		Cheryl Harding	(Mother				., Highl		
Baltimore,	Segue = 50		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ Rem	oval from State	20b. Place of Dispo cemetery, crer	sition (Name of natory or other plac	e)			ty or Town, State
Ħ	it. Partitude		*4 □ Donation 5 □ Other (Specify)  21. Signate of Funeral Service Lines see					3/12/05		
Ba	permi Depar Impor any ir		1 2014 / C	Arros						Home, P.A. MD 20850
	. AF		23a. Part1. Enter the disease, or complicate shock, or head failure. List only one of	ons that caused						Approximate
	Physician		Immediate Cause (Final disease or condition	ause on each lin	milto	7- 6	1 1	1100	0 -	Interval Between Onset and Death
<b>*</b>	/Medical		resulting in death)	Due to (or as a	a consequence of):	ac o a	18-31	vous	ELL	
	Examiner		Sequentially list conditions. b							
	ed sit	Examiner	Sequentially list conditions, flary, leading to shired late cause. Enter Underlying Cause, (Disease or injury that initiated events	. Una to (or se a	recresquence of):					
	xecut and	хап	that initiated events resulting in death) Last	Due to (or as a	consequence of):					
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and agge 2 should be detached for use as the burial-transit	dicai E		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						
.89	ifficati g phy as the	edic	0							
Вох	eath certific attending p for use as	In/M		If yes, outcome o		e . 1911 15.75			23d. Date o	f delivery
Э. В	the att	sicia	1 Yes 2 No	4 Pregnant at t		Ectopic pregnancy Other (specify)			Month	Day Year
P.0	that the ded by the	Physician/Me	a Clikilowii							
Š,	ires tha signed t be de	þ	Part II. Other significant conditions contrib	uting to death bu	t not resulting in the ur	iderlying cause give	en in Part I.		A a	ite to the cause of death?
Records,	w requir been si should I	Completed						1 🗆 Yes	2 No 3[	Probably 4 Unknown
Rec	The lav ate has page 2 :	mpi		<del> </del>				24a. Was an autopsy	prior	re autopsy findings available r to completion of cause of
		°C	25. Was case referred to medical					Yes 2		Yes 2 No
>	Physician: this certific al director,	0 8	examiner?  1 🔀 Yes 2 🗌 No Hosp	ıtal: 1 ☐ Inpatien	nt 2 XER/Outpatien	3 DOA Othe		th (Check only one)	A 57011	
	ig Phy ter thi	h: T	27. Manner of Death 2	8a. Late of hjury		28c. Injury Work		ome 5 Residence 28d. Describe how		Specity)
ioi	Attending I r death. ector: After by the funer	atio	2 Accident investigation	3/7/05	HOS Injury	M 1 Y		Subje	at 81	25
Division	or Att	Certification:	3 Suicide 6 Could not be determined 2	84 Place of Inju- building, et /.	, - At home, farm, stre	et, factory, office		28f. Location (Stree City or Town, S	at and Number c	or Ru al Route Number,
	Hospital of the hours at Eunarat D				afterg	-oV		3000 61	K. S. 6	ton Ave
	Hos 24 ho Fun stely f	Medical	29a. Certifier (Check only one)  1 Certifying Physicia 2 Medical Examiner:	On the basis of e	examination and/or inv	occurred at the time estigation, in my op	e, date and place, inion, death occur	and due to the caus	e(s) and manne and place, and	r as stated. due to the cause(s)
	To the Hospital or Attendi within 24 hours after death. To the Funarat Director: A completely filled in by the fu	Me	29b. Signati reacht, little of ertifier	and manner state	ou.	29c. License				fonth, Dey, Year)
	4		V/ woke in	(1)		OCM			March 8,	
_	1		30. Name and address of person who comple	eted cause of de	ath (Item 23a) (Type, F			(I)		
			J LARON GOL	E, NH			n Street	Baltimo:	re. Mars	7land 21201
•	Sta Registr		31. Date filed (Month, Day, Year)  MAR 1 1 2005	32 Registrar	's Signature	le le			,	

			1 - For State Registrar	State of M	aryland		rtment o			nd M		- /	005		10330
Sin	New Comment		Decedent's Name (First, Middle, L.				imouto	01 2			2. Date of De	Reg. No.			3. Time of Death
	Physici /Medic		NORMAN	YRF	SLE	Y					Month O3	Day CO	Yea O.Q.		5 413 PM
	Examir		4a. Facility Name (If not institution, g	ive street and number)			4b. City, To	wn, or	Location of	f Death		40	County of D	aath	2721
				DRGES !	rtosp	CIR	CHE	EV	ERL	4		P	RINCI	3 (	GEORGES
	Funeral			Sex 7. Ag 1 ☐ M 2 ☐ F	e (In yrs. las		If Under 1 Y	Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birt (Month, Da	h	9. E	Birthpla Countr	ice (State or Foreign
	Director		579-40-5178 Usual Residence of Decedent	Xwz	74	Yrs.					01 21	1931	Wa	shi	ington, DC
	land ow		10a. State 10b. County		10c. City, 1	Town or Loc	ation							10	d. Inside City Limits
	Many Ff sh	to	MD P.G.		Tem	ple H	ills								1 Yes 2 No
	or 286	lrec	10e. Street and Number				10f. Zip Co	ode			T	10g. Citiz	en of What	Countr	y?
	within 72 hours after death with the Maryland ene. than "naturat", or items 23e or 28e-f show is Medicul Examinat must be rotified at	Funeral Director	3520 Dunlap Stre	et			20	748				U.	S.A.		
	r dea	ne	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. V	as Deceden Yes, specify	t of His	panic Orig	in? (Spe	cify Yes or No-	. 1	4. Race - Ar Black, W		
36	s afte	by Fi	1 ☐ Never Married 2☑ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	No		☐ Yes 2万元		Specify:		, 2,0,7		Specify: P		
00	hour	ed b	15. Decedent's	Year or Dates:		162 Doord	ent's Usual C		Name .						
15	n na	Completed	(Specify only highest g	rade completed)		(Give I	and of work of NOT use r	done du	uring most	of workii	ng	10D. KIN	d of Busine:	ss/Indu	stry
212	d with	E	Elementary/Secondary (0-12) 12th	College (1-4or 5		Gener	al Exp	edi	tor			U.S.	Post	al	Svc
b	be filed tal Hygid of other event, I	Bec	17. Father's Name (First, Middle, Las	,					18. Mother	's Name	(First, Middle,				
<u>Vla</u>	should be filed within and Mental Hygiene. I marked other than umatic event, I'E M.	<b>1</b> 0	Norman Presley						Edi	th S	Stevens	on			
Maryland 21215-0036	2 sho and is m		19a. Informant's Name/Relationship								l Route Numbe			, Zip C	code)
	ss 1 and 2 of Health itam 27 i		Juanita B. Presl	ey - Wife					reet;		ple Hi			074	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menial Hygiene. Important: if item 27 is marked other than "natural; or items 23s or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.		20a. Method of Disposition  12 Burial 2 Cremation 3	☐Removal from State	Resu	e of Dispos etery, crem	ition (Name of atory or other LON CE	of r place M	03		<sup>4te</sup> 2005		ation - City on the contract o		
ij	rtmer rtant rtant		'4 □Donation 5 □Other (Spec		1	_						CIII	10011,	tat	yrand
Ba	permit. Pages Department of Important: If i any injury or one		21. Signature of Funeral Service Lice	eenar	)		reeman reeman								
			23a. Part   Enter the disease, of cor	nolications that caused	the death. I	Do not ente	O. BO	X 4 f dving	16; S	ouit.	land, Ma	aryla	ind 2	075	2 approximate
	Physician		Immediate Cause (Final	y one cause on each iir	ne.									lr.	nterval Between Inset and Death
	Physician /Medical		disease or condition resulting in death)	a. INTRY	3 CODSEGUE	(E (D)	AL	1,	ier4	OKA	LHAC	E		1	WEOK
	Examiner			HY	PER	TEN	510	0						1	YEAR
	7 7	ner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying	Due to (or as								-			
	ecuted and transi	Examiner	that initiated events	c.										3	
, 0,	cate be executed physician and the burial-transit	EX	resulting in death) Last	Due to (or as	a consequen	ice of):								I	
8760,	cate be executed physician and the burial-transit	dical		_ d.									_	1	
9 X	E Do es	Physician/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy	,								-	
Вох	it the death cer by the attendin tached for use	clan	23b. Was decedent pregnant in the past 12 months?	1□Live birth 4□Pregnant at	2 Fetal de	ath 3□I	Ectopic pregn Other (specif					23	3d. Date of d Month	elivery Da	
O.	0 00 0	Jys	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	time or death	, 50	Ottor (Specia	y/							
s, P	res that igned b	by PI	Part II. Other significant conditions	contributing to death be	ut not resultir	ng in the un	derlying cause	e giver	in Part I.		23e. Did to	bacco us	e contribute	to the	cause of death?
rd	w require been sig should b										1□Y	es 2 🗆	No 3 □ 1	Probab	ly 4 <del>x</del> 2Unknown
Record	a 25 C4	plet									24a. Was a		24b. Were	autops	y findings available
		Completed									autops perfor		death?	?	letion of cause of
Vital	Attanding Physicien: Th r death. actor: After this certificate by the funeral director, pag	Be (	25. Was case referred to medical examiner?							of Death	(Check only or				
	Physi this c	P	1 ☐ Yes 2 No	Hospital:		Outpatient	7.0	Other	4 🗆 Nurs		ne 5 ☐ Reside			ecity)	
Division of	ding I h. After funer	lon	27. Manner of Death  1 Natural 5 Pending	28a. Date of Injur (Month, Day	y Year) 28	b. Time of Injury		Work?			8d. Describe h	ow injury	occurred		
ls l	or Attan after deatl Diractor; in by the	flca	2 Accident investigation 3 Suicide 6 Could not lead to determine	oe Olean of Init	urv - At home	farm, stre			es 2⊡No		8f. Location (Si	root and	Numberor	Dural D	auto Mumbas
2	al or A after 1 Dirac d in by	Certification;	4 Homicide	building, etc		, 14.111	ot, lastory, on	1100		-	City or Town	1. State)	vuinber or r	nurai n	oute rvumber,
	To the Hospital or A within 24 hours after To the Funaral Dirac completely filled in by		29a. Certifier Check only 2 Medical Exa	hysician: To the best of	of my knowle	dge, death	occurred at th	ne time	, date and	place, a	nd due to the c	ause(s) a	nd manner a	as state	ed.
	the H in 24 tha F iplete	ledical	one)	miner: On the basis of and manner sta	examination	and/or inve	stigation, in r	my opir	nion, death	occurre	d at the time, d	ate and p	lace, and du	e to th	e cause(s)
	To To To To To To To To To To To To To T	Σ	29b. Signature and title of certifier			5	29c. Lic	cense r	number		2	9d. Date	signed (Mor	ith, Da	y, Year)
			pusuf	Ycclain	M	r 1).	100	200	514	85		03/	06/	20	20
R	(13)			completed cause of de			75 12	00	7 R	IVE	R G	ATI	EL	A	NE
	Sta	te	31. Date filed (Month, Day, Year)	P. Registra	ar's Signature	AIN	_ 6	00	310	0 8	MD,	_2	07	15	
	Registra	_	MAR 1 1 2005		K	Spood	e e								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** AN PLACE HILDA MARTHA 3 05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Allegani scred Heart Hospital umber land If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Min 1 ☐ M 2 💢 F 091-18-7623 88 Director 23,1916 NEW YORK Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other then "naturel", or items 23s or 28e-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r items 23a or 28e-f show incrmust be relified at 1X Yes 2 No Director ALLEGANY CUMBERLAND MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21502 505 MAGRUDER STREET U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: other traumatic svent, the Medical Evan Completed by 3 Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) WAITRESS RESTAURANT 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 ALANSON SCHOONMAKER ETHEL GERMAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 505 MAGRUDER STREET, CUMBERLAND, MD EDITH DAMM / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State permit. Page Department c Important: if any injury or ò 4 ☐ Donation 5 ☐ Other (Specify) CUMBERLAND CREMATORY 03/15/2005 CUMBERLAND, MD 21. Signature of Funeral Service Licenses UPCHURCH FUNERAL HOME, P.A. 202 GREENE STREET, CUMBERLAND, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21502 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Que to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed physician and s the burial-translt Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760 Physician/Medicai use as I IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death 1 Live birth ò in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown signed by the a d be detached fo 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 🗆 No 3 Probably should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 2 🗆 No 1 🗌 Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one, examiner' Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 🗌 Yes Inpatient 2 ER/Outpatient 3 DOA this Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funerel Director: A completely filled in by the fu investigation Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitei Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29d. Date signed (Month, Day, Year) 29c. License number 29b. Sigria Name and address of person who completed cause of death (Item 23a) (Type, Print) かんり omberland MD Dert 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Marylar		artment of F		-	giene Reg. No. 105	10332
}	Physic /Medi Exami	cal	1. Decedent's Name (First, Middle, Las.  Robert C,  4a. Facility Name (If not institution, give	Pike		4b. City, Town, or	r Location of Dea	2. Date of De. Month Marc.	h 11 200 4c. County of Dea	5 0/40 AM
	Funeral Director		5. Social Security Number 6. Security Number 024-16-6802 Usual Residence of Decedent	TM 2DE	last birthday) 32 Yrs.	If Under 1 Year Months Days	If Under 24 Hr. Hours Mir		y Year) 9. Bi 923 Mai	rthplace (State or Foreign country) ssachusetts
	d 2 should be filed within 72 hours after death with the Maryland th and Mental Hyglene. 7 is marked other than "natural", or items 23s or 28s-f show treumatic event, the Ne Lical Examinar must be invitible at	Funerai Director	MD Worcester  10e. Street and Number  2049 Orchard Drive	Poc	ity, Town or Lo				10g. Citizen of What C	10d. Inside City Limits 1X Yes 2 □ No country?
-0036	72 hours after deat "natural", or items?	þ	11. Marital Status  1 Never Married  Married  3 Widowed 4 Divorced	12. Was Decedent Ever in L Armed Forces? 13€1Yes 2 □ No If Yes, Give Year or Dates: WW	II	Vas Decedent of H f Yes, specify Cuba ☐ Yes 2 <sup>th</sup> No lent's Usual Occupi	Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Whi	ite, etc. hite
d 21215-0036	a filed within 72 Il Hygiene. other than "ne vent, the Me Li	e Completed	(Specify only highest grad  Elementary/Secondary (0-12)  12  17. Father's Name (First, Middle, Last)	de completed)  College (1-4or 5+)  1	(Give life. L	kind of work done of the NOT use retired	during most of wo	]	16b. Kind of Business  Federal Gov  Maiden Sumame)	
Maryland		To Be	Osborn B. Pike  19a. Informant's Name/Relationship (T)		Navanoe o	and all the same	Lilla M	. Conner	r, City or Town, State,	
Baltimore,	permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tru 2008.		Blanche E. Pike  20a. Method of Disposition  1 (X)Burial 2 Cremation 3 F  4 Donation 5 Other (Specify)  21. Signature of Fundral Service Licens	Removal from State Fin	Place of Dispos cemetery, crem <b>St Bapti</b> :	sition (Name of natory or other place st Cemetery	3/13	Date 3/2005	ty MD 2185 20c. Location - City or Pocomoke C	Town, State
Ba	permit. Departm Importa any inju		23a. Part 1. Enter the disease, or complishock, or heart failure. List only or	COS lications that caused the deal	th. Do not ente	Olloway N 03 Linder or the mode of dying	Melson F  Ave.,  g, such as cardia	uneral Ho Pocomoke c or respiratory are	ome, P.A. City, MD 2	Interval Between
	/Medical Examiner	Examiner	if any, leading to immediate cause Enter Underlying Cause (Disease or injury	Due to (or as a consequence to consequence).		0	ence			Onset and Death
Box 68760,	death certificate be executed e attending physician and ad for use as the burial-transit	dicai	resulting in death) Last	Due to (or as a conseq d	ancy	- 11			23d. Date of de	liven
P.O.	t the by th ache	Physician/Me	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  Part II. Other significant conditions cor	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	leath 5□	Ectopic pregnancy Other (specify)	n in Cod I	220 Did to	Month bacco use contribute to	Day Year
Vital Records,	aw requires is been sign 2 should be	ompieted by			State of the state	donying cause give		×.	es 2 No 3 Pr	robably 4 Unknown
f Vital R	lysicien: The is certificate director, pag	To Be Con	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	lospital: Mapatient 2	ER/Outpatient	3□ DOA   Othe		perform 1 ☐ Yes	death?	
vision	I or Attending Ph after death. Director: After th In by the funeral	Certification:	27. Manner of Death   Natural   5	28a. *ate of Injury (Month, Day Year)	28b. Time of Injury		at	28d. Describe ho	ow injury occurred treet and Number or Ru	
5	Hospitel or 24 hours afte Funerel Din tely filled in	edical Cert	29a. Certifier To Certifying Phys	building, etc. (Specify sician: To the best of my kno ner: On the basis of examina and manner stated.	y)	occurred at the time	e, date and place inion, death occu	City or Town	n, State)	chatad
)	To the within 2 To the Comple	Me	29b. Signature and title of certifier	00/	me	29c. License	number 7 (	2	9d. Date signed (Month	1-05 1-05
1	Sta Registr		30. Name and address of person who co AUN COLLAL 31. Date filed (Month Pax Year) AR 1 4 20	L.MO P.O	1. 150)	173;	3 5	elist	) MO	21862

		1	For Stete Registrar	State of M	arylan				lealth an Death	nd Menta		ene g. No	005	10333
			Decedent's Name (First, Middle, Las.)	t)							te of Death	1		3. Time of Death
	ysicia		П	C		Dat	tters	on			onth	Day 200!	Yeer 5	8:00a <sup>M</sup>
	/ledica amine	_	Herman 4a. Facility Name (If not institution, give	street and number,	)		1		Location of E		LII II 9		unty of Death	
	ammic		Kensington Park R	otirement	Care		Kei	sing	ton			Mot	ntgome	rv
Fund	eral		5. Social Security Number 6. Se	7. A	ge (In yrs.	last birthday)		er 1 Year	If Under 24	Hrs. 8. Da	te of Birth		9. Birth	place (State or Foreign intry)
Direc			308 22 4139	M 2□F	80	Yrs.	MOHAH	Days	Hours		y 20.		1	diana
pu ,	-242	-	Usual Residence of Decedent		10a Cit	y, Town or Lo								10d Inside City Limite
aryla	3		10a. State 10b. County		TOC. CIL	y, Town or Lo	ocation							10d. Inside City Limits 1 ☐ Yes 3€ No
98 Ba-1	THE STATE OF	Director	Maryland Montgom	ery	Ker	singto								
vith th	Dan.	5	10e. Street and Number				10t. 2	ip Code			110	g. Citizen	of What Cou	intry?
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er de	O DELL'	Funeral	11. Marital Status	12. Was Decedent	? No		Was Dec If Yes, sp	edent of Hi ecity Cuba	ispanic Origin ın, Mexican, P	Puerto Rican,	etc.)		Race - Ameri Black, White,	
36 rs aft		by F	1 ☐ Never Married 2 ☐ Married 3 🎛 Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ If ¥es, Give Year or Dates:	NO W	II I	1 🗆 Yes	2 No	Specify:			Spi	ecity: W	hite
1215-0036 within 72 hours after death with the Maryland ene. then "natural", or Items 23e or 28e-f show	injury prother traumatic event, the Madical Expression of the notified at in.	ba -	15. Decedent's Ed			16a. Dece	dent's Us	ual Occup	ation			6b. Kind o	of Business/Ir	ndustry
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d be ental	C BV	To Be	Halmorm						Unkne	OF.III				
Maryland 2. d 2 should be filed v th and Mental Hygie 77 is marked other t	mat	-	Unknown 19a. Informant's Name/Relationship (7	ype, Print)		19b. Maili	ng Addre	ss (Street a	and Number of		e Number,	City or To	wn, State, Zi	p Code)
Ma rd 2 :: Ith ar	tra		William J. Davis	/ Step-s	ΩD	1939	Ric	cev R	oad Max	x Mead	ows.	Vire	inia 2	4360
Baltimore, Maper I and 2 Department of Health at Importent: It item 27 is	othe	-	20a. Method of Disposition	7 BEEP B	20b. F	Place of Dispo	osition (A	ame of	- 1	Date	-		ion - City or T	
ages int of	de		1 Burial 2 Cremation 3 C		·	semetery, cre	-				_			
Baltimore, permit. Pages 1 a Department of Hee mportent: It item		1	* 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service License	1	Par	rklawn	Memo 2. Name	orial and Addres	Park ss of Facility	3/11/0	5 R	ockv:	ille, i	Maryland
Ba Perm Depa Impo	eny ir	ı,	1 1 1 1 1	Stock to					ss of Facility					
		-	23a. Part1. Enter the disease, or comp	plications that cause	d the deat								Spring	MD 20904 Approximate
Physic /Med Exami	ical iner	ner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a. Acute M Due to (or a: Due to (or a:	y Art	tery D			n					Onset and Death
8760, rate be executed ohysician and	he bui	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Cardion  Due to (or as										
O. Box 6 the death certific the attending p	or use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 🗌 Feta	ıl death 3[	⊒Ectopic ⊒ Other	pregnancy specify)	'			23d.	Date of deliv	rery Day Year
Records, P. he law requires that he has been signed by	9	ρ	Part II. Other significent conditions of	ontributing to death	but not res	ulting in the u	ınderlyin	cause give	en in Part I.	23		acco use o s 2. arN		the cause of death? bably 4 ∐Unknown
w requ	shou	Completed								24	a. Was an	2	4b. Were auto	opsy findings available
Rec The law ate has b	ge 2	ᇤ								-	autopsy perform	ed?	prior to co death?	ompletion of cause of
	r, page											<b>№</b> No	1 🗆 Yes	2□ No
of Vital F Physicien: Th this certificate	al director,	Be	25. Was case referred to medical examiner?	Hospital:				Oth	00	f Death (Che				
of Physic	i di	2	1 Yes 2X No	1 Inpat		ER/Outpatie		JUA	4 (				Other (Speci	fy)
Jing P	nuer	on	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Inj (Month, D	ay Year)	28b. Time o	M	28c. Injun Worl	yat k? Yes 2 □ No		escribe ho	w injury oc	MII BO	
or Attendiffer death	in by the f	Certification	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Ir	njury - At h	ome, farm, st			165 2 100	28f. Lo	cation (Str ty or Town		umber or Rur	al Route Number,
To the Hospitel within 24 hours a	completely filled in by the funer	Medical C	29a. Certifier (Check only one)	ysicien: To the bes niner: On the basis and manner s	of examina	owledge, dear ation and/or in	th occurrenvestigati	ed at the tin	ne, date and p pinion, death	place, and du occurred at t	e to the ca he time, da	use(s) and te and pla	d manner as sice, and due t	stated. to the cause(s)
To th To th	сошр	Me	29b. Signature and title of certifier	- 1	1		- :	9c. Licens	e number		29	d. Date si	gned (Month,	Day, Year)
->-	,		· AXA	110ck	>1/2	N	M	D5	3691			Maı	rch 10	2005
6			30. Name and address of person who	completed cause of	death (Iter	m 23a) (Tvpe	Print)							
_								·hoc 3	. W	nland.	20017			
	Stat	e	Ajay Reddy, M. D. 31. Date filed (Month, Day, Year)	32 Regis	loctac trar's Signa	amile BIA	Be	nesd	a, Mar	утапа	ZNQT/			
Bo	ola: enietre		MAR 1-1 20	105		1. At	54CL							

			1- For State of Maryland / Dep	partment of Health and Nertificate of Death		ene 005	10334
			Decedent's Name (First, Middle, Last)		2. Date of Death Month	1	3. Time of Death
	Physicia /Medic		Veva Royal Price		March	13 2005	7.45PM
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			Eden Pines Asst Living	Hagerstown  If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	Washingto	n County  place (State or Foreign
	Funeral Director		5. Social Security Number  6. Sex  1 M 2 F 7. Age (In yrs. last birthda)	Months Days Hours Min.	(Month, Day,	Year) Cour	ntry)
			Usual Residence of Decedent		Feb 27 1		
	irylan show	_	10a. State 10b. County 10c. City, Town or	Location		1	Od. Inside City Limits
	8a-f s	Director	Maryland Washington Ha	gerstown	1.40	(148 + 0	XXYes 2 No
	with th	F	10e. Street and Number	10f. Zip Code		g. Citizen of What Cour	•
	eath v	eral	310 Cameo Drive  11. Marital Status 12. Was Decedent Ever in U.S. 13	Hagerstown  New Mass Decedent of Hispanic Origin? (Si		Jnited Stat	
_	r Item	Funeral	1 Never Married 227 Married 1 ☐ Yes 2 127 No	B. Was Decedent of Hispanic Origin? (S) If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White,	
3	72 hours after death with the Maryland natural', or Items 23e or 28e-f show deal Examiner must be notified at	þ	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		SpecifyWhit	e 
- -	72 ho 'natu	Completed	(Specify only highest grade completed) (Gir	cedent's Usual Occupation ve kind of work done during most of work	king 1	6b. Kind of Business/In	dustry
7	within ne. than	du	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired) Teller		Banking	
V	Hygie Hygie ther t	e Co	12 17. Father's Name ( <i>First, Middle, Last</i> )		ne (First, Middle, M		
<u>a</u>	ld be ental ked o	To Be		Lillian	Agnes Ro	oyal Peet	
<u></u>	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene and Mental Hygiene ls marked other than "natural", or liems 23a or 28a-f show termitic event, the Medical Examiner must be notified at	-	Owen V. Peet  19a. Informant's Name/Relationship (Type, Print)  19b. Ma	iling Address (Street and Number or Ru			Code)
Ž	alth a alth a 127 ls		Marsha Mauriello (Daughter) 128	27 Fountain Head R	toad Hager	rstown Mary	land 21742
e G	es 1 a of He of Hem		cometent of	position (Name of rematory or other place)		Oc. Location - City or To	
Ĕ	Pag ment ant: I ury o		1 Burial 2 Tormation 3 Removal from State 4 Donation 5 Other (Specify)	ourg Crematory Mar	15 2005	Smithsburg	
Baltimor	permit. Pages 1 and 2 should by Department of Health and Menta Important: If Item 27 Is marked any injury or other traumatic er		21. Signature of Funeral Service Licensee	22. Name and Address of Facility DC 1331 Eastern Blvd.			
П	A**	7	23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arres	st,	Approximate Interval Between
	Physician			s Disease			Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):				7
	LXammer	_	Sequentially list conditions, than leading to immediate b				-
	ted nsit	nlne	cause. Enter Underlying Cause (Disease or injury				
	al-tra	Examine	that initiated events resulting in death) Last C. Due to (or as a consequence of):				
9/90	cate be executed oblysician and the burial-transit	dical	d				
9	tificating phy as the	ledi					
POX	death certificate be executed e attending physician and od for use as the burial-transi	an/N	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3	3 □Ectopic pregnancy		23d. Date of deliver	ery Day Year
o D	w requires that the death certific been signed by the attending p should be detached for use as	Physiclan/Me	in the past 12 months?  1  Yes 25 No 9  Unknown  1  Unknown	5 ☐ Other (specify)		Mortu	Day Foal
7.	requires that the leen signed by th hould be detache			underlying cause given in Part I.	23e. Did toba	acco use contribute to the	he cause of death?
Vital Records,	signe d be d	Completed by	Husethroid in Atheros		lan 1 Yes	s 2 <mark>X</mark> No 3□Prot	pably 4 □Unknown
Ö	v requ	lete	Piseuse Cormary artery	diseases.	24a, Was an	24b. Were auto	ppsy findings available
Ě	The law ite has b	dmo	Piseuse, Cormary artery	a 138954	autopsy perform	prior to co death?	mpletion of cause of
g	(0 ===	e C	25. Was case referred to medical	26. Place of Dea	th (Check only one		2□ No
	Physician: The laviths certificate has	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat	Other	ome 5 Resider	V/	S) ASSITING
יס ר	<b>5</b> = E		27. Manner of Death 1. Natural 5 □ Pending 28a. Date of Injury (Month, Day Year) 28b. Time Injury		28d. Describe how	w injury occurred	3
<u>o</u>	death. ctor: Af y the fur	atlc	2 Accident investigation	M 1 Tes 2 No			
Division		Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Str. City or Town,	eet and Number or Rura , State)	al Route Number,
_	spital ours and neral filled		29a. Certifier 1 Certifying Physician: To the best of my knowledge, de	eath occurred at the time, date and place	, and due to the car	use(s) and manner as s	stated.
	To the Hospital or within 24 hours after To the Funeral Director Completely filled in b	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occu	rred at the time, da	ite and place, and due to	o the cause(s)
	To the to the total	Σ	29b. Signature and title of certifier	29c. License number		3d. Date signed (Month,	
)			> May € illney b)	023815	5	2 ~ 1 7 - 0	<i>&gt;</i>
24	1-10		30. Name and address of person who completed cause of death (Item 23a) (Type Mary & Woney, WD 354 Millst	, Hacerstown,	mn 2	1740.	
		ate rar	31. Date filed (Month, Day, Year)  NAR 16 2005  32. Registrar's Signature	peles peles			
			1	/			

SERGE G. PATRICK    ABOUT 100			1- For Amend Item #13 State Registrar WCHD/SH 3/1  1. Decedent's Name (First, Middle, Lasi	5/05 per FH	nd / Department of F Certificate of	Death	I Hygie	4000	10335
5. Decel all Security Number   279-12-36    35	/Medi	cal	GEORGE G. P. 4a. Facility Name (If not institution, give	ATRICK street and number)		Marc Marc or Location of Death	h 10,	2005 4c. County of Dea	10:20pm
Top   Dispute			Social Security Number     6. Se	X 7. Age (In yrs.	last birthday) If Under 1 Year	If Under 24 Hrs. 8. Date (Mo	nth, Day, Ye	ar) 9. Bii	thplace (State or Forei
23. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interest Between the shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition of the complete of t	10.000	tor	10a. State 10b. County			,		,)	10d. Inside City Limit
Sequentially list conditions in the past 12 months?   1   1   2   2   No   3   Probably 4   2   2   No   3   Probably 4   2   2   No   3   Probably 4   2   2   No   3   Probably 4   2   2   No   3   Probably 4   2   No   3   Probably 4   2   No   3   No   No   No   No   No   No	ust be not	ral Direc	10e. Street and Number		10f. Zip Code		10g.		
Part   Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between the special part of the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between the special part of the speci	Examinero	d by Fune	1 Never Married 2 Married	Armed Forces? 1 ∰Yes 2 ☐ No If Yes, Give	If Yes, specify Cuba		s or No- itc.)	Black, Whi	te, etc.
Part   Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between the special part of the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between the special part of the speci	the Medica	Complete	(Specify only highest grad	e completed) College (1-4or 5+)	(Give kind of work done of life. DO NOT use retired	during most of working MANUFACTURER	'S G	Kind of Business SHEN MANU	Andustry FACTURING
Approximate finding and sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between shock, or heart failure. List only one cause on each line.    Approximate finding and sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and shock, or heart failure. List only one cause on each line.    Approximate including a such as cardiac or respiratory arrest, and shock, or heart failure. List only one cause on each line.   Due to (or as a consequence of):	natic event	Be	AUSTIN LATHROP			MARGUERIT	E PAYS	SON	
23a Part   Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between shock or heart failure. List only one cause on each line.	other treun		JEAN PATRICK/SPOL 20a. Method of Disposition	JSE 20b. F	327 NOTTINGH	AM BLVD., MAR	TINSBU	JRG, WV 2	25401
Part   Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between the disease or conditions of the condit	y injury or Ce.		`4 ☐ Donation 5 ☐ Other (Specify)	SM.	ITHSBURG CREMATORY	11, 2005	SI	MITHSBURG,	MD
Due to (or as a consequence of):    Due to (or as a consequence of):   Due to (or as a	ician dical niner	ner	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence)	n. Do not enter the mode of dyin perce of):	g, such as cardiac or respira	WV 254 tory arrest,	102 W. KII	Approximate Interval Between Onset and Death
25. Was case referred to medical examiner?  1		ical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de	ncy death 3□Ectopic pregnancy				•
25. Was case referred to medical examiner?  1		d by Phys	Part II. Other significant conditions con	tributing to death but not resu		en in Part I. 23e			
The state of the s	page 2		pypertona				autopsy performed?	/ prior to death?	completion of cause of
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)	this al di	ToB	examiner? 1 Yes 2 No  27. Manner of Death	28a. Date of Injury	ER/Outpatient 3 DOA Other	ar: 4 Nursing Home 5	Residence	6 □Other (Specury occurred	ify)
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check only one)  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)	d in by the fu	ertification	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At ho	M 1 ☐ Y	/es 2 □ No 28f. Loca	tion (Street a or Town, Sta	and Number or Ru te)	ral Route Number,
29c. License number  29d. Date signed (Month, Day, Year)	the Funere	edical C	(Check only 2 medical Examir	ier: On the basis of examinat	vledge, death occurred at the tim ion and/or investigation, in my op	e, date and place, and due t inion, death occurred at the	o the cause( time, date ar	s) and manner as nd place, and due	stated. to the cause(s)
D18019 MARCH 11, 2004	,	Σ	29b. Signature and title of certifier	ND	29c. License		29d. D	ate signed (Month	Day, Year)

			For State Registrar	tate of Marylan		partment of F e <i>rtificate of</i> .		-	giene Reg. No.		
	Physici	20	Decedent's Name (First, Middle, Last)					2. Date of De Month	ath Day	Year	3. Time of Death
	Physici /Medic	al	Kenneth Keith		by	4h City Tourn o	r Location of Death	03	18	County of Death	013500
I	Examin Funeral Director	er	4a. Facility Name (If not institution, give stree  SACTE A HEAR+  5. Social Security Number  6. Sex  219-14-6276	HOSDITAL 17. Age (In yrs.	last birthda Yrs.	Cumbe	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	F	TheG	Place (\$tate or Foreign
	and		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or	Location					10d. Inside City Limits
	Maryl	tor	MD Allegany		Cum	berland					Y☐Yes 2☐No
	or 28s	Funeral Director	10e. Street and Number	- 4		10f. Zip Code	24500		10g. Citiz	zen of What Cou	ntry?
	eath v	erai	7 Long Drive	Vas Decedent Ever in U	.S. 1:		21502	ecify Yes or No	- 1	USA 14. Race - Ameri	can Indian.
21215-0036	be filed within 72 hours after death with the Maryland all Hygiene. All Hygiene. All Chier than "natural", or Items 23a or 28a-f ahow other than "natural", or Items 23a or 28a-f ahow avent. If a Medical Exativity or must be inclined at	by	1 Never Married	Armed Forces?  Yes 2 No Yes, Give Year or Dates: WWII		3. Was Decedent of H If Yes, specify Cubs 1  Yes  No	Specify:	Rican, etc.)		Black, White, Specify: whit	etc.
<u>5</u> -0	"natu	letec	15. Decedent's Educatio (Specify only highest grade con	n mpleted)	(Gi	cedent's Usual Occup ve kind of work done b. DO NOT use retired	durina most of work	ring	16b. Kir	nd of Business/Ir	ndustry
212	iene. rthan	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Labor		2)		Colu	mbia Ga	S
ਰੂ	0 - 0 5	Be	17. Father's Name (First, Middle, Last)  Clarence Roby				18. Mother's Nam	e (First, Middle,	Maiden		
Maryland	2 should be and Mental I is marked o aumatic ave	To	19a. Informant's Name/Relationship (Type, I	erint) wife		niling Address (Street			er, City or		D 21502
Baltimore, N	permit. Pages 1 and 2 should by Oppurment of Health and Menta Imperiant: If Itam 27 is marked any injury or other traumatic at Once.		Dorothy Roby  20a. Method of Disposition  1 ⊠ Burial 2 □ Cremation 3 □ Remo	20b. F	Place of Dis	ong Drive	ce)	Date	20c. Loc	cation - City or T	own, State
	it. Pa intmen intent: njury		<ul> <li>4 □ Donation 5 □ Other (Specify)</li> <li>21. Signature of Funeral Service Licensee</li> </ul>	St. I	viary s	Cemetery 22. Name and Addre		3/21/2005	Cun	nberland	MD
ä	Dep de la company de la compan		Yann +	Man	2'	22. Name and Addre Scarpelli 108 Virg	i Funeral Ho inia Avenue		land I	MD 21502	
	Physician		23a. Part. Enter the disease, or complicatic shock, or heart failure. List only one call immediate Cause (Final disease or condition	ons that caused the deat luse on each line.							Approximate Interval Between Onset and Death 2 COYS
	/Medical Examiner		resulting in death)	Due to (or as a conseq		ing (	anced				1 mall
		ner	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseq			DVICEO				6(
*	ecuted and -transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						
-,09789	iicate be executed physician and s the burial-transit		d =	Due to (or as a conseq	dence on:						
		Aedicai	JESCHALE.								
P.O. Box	taw requires that the death certifias been signed by the attending 2 should be detached for use as	Physician/M	in the past 12 months?	f yes, outcome of pregna I□Live birth 2 □ Feta I□Pregnant at time of d I□Unknown	death 3	3 □Ectopic pregnancy 5 □ Other (specify) _	/		2	3d. Date of deliv Month	ery Day Year
ώ.	w requires that the de been signed by the should be detached	by Pr	Part II. Other significent conditions contribu		1		en in Part I.	23e. Did to	obacco us	se contribute to t	he cause of death?
ord	require sen sig nould b		Brenchop	1eu 6 m	hist	ula		1 🗆 '	res 2	No 3 Prol	pably 4 Nnknown
Y	The ate h	Completed							an rmed? 2 \square No		opsy findings available impletion of cause of 2 No
VII.	nysiclen: Th	o Be	25. Was case referred to medical examiner?	ital:	FD/0	iont 20 DOA Oth	26. Place of Deat			Dou 10	
on of	Ing Pt	$\vdash$	1 ☑ Natural 5 ☐ Pending	Ba. Date of Injury (Month, Day Year)	28b. Time Injun	of 28c. Injur	4 LI Nuising no	28d. Describe I		Other (Special occurred	(y)
Division of	or Attand after death Director: /	Certification;	3 Could not be	Be. Place of Injury - At he building, etc. (Specif				28f. Location (S City or Tov		l Number or Rura	al Route Number,
	To the Hospitel or Attanding Physician: which 24 hours after death as a fine death is certified To the Funerel Director: After this certified completely filled in by the funeral director, i	edical C	29a. Certifier 1 Check only one) 1 Certifying Physicie 2 Medical Exeminer:	n: To the best of my kno On the basis of examina and manner stated.	owledge, de ation and/or	eath occurred at the tir investigation, in my o	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s) a	and manner as s place, and due to	stated. to the cause(s)
	within To th Comp	M	29b. Signature and title of certifier			29c. Licens				signed (Month,	
	P		30. Name and address of person who comple DR, Afaq AhmaD	eted cause of death (Item	n 23a) (Typ	e Print)		D. MD			
	Sta	te	31. Date filed (Month, Day, Year)								
	Registr	ar	MAR 2 5 2005	32. Registrar's Signa	Right	West -					

			State of Maryland / D	Department of Health and Me Certificate of Death	•	ne O O O C
	Physici /Medio		1. Decedent's Name (First, Middle, Last)  Ellsworth V. Rosenmarkle	N	2. Date of Death Month IARCH 17,	2005 Year 3. Time of Death 7
	Examin		4a. Fecility Name (If not institution, give street and number)  Memorial Hospital	4b. City, Town, or Location of Death CUMBERLAND		4c. County of Death ALLEGANY
	Funeral Director		5. Social Security Number  6. Sex 1 M 2 F  7. Age (In yrs. last bin 1 M 2 F  Usual Residence of Decedent	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye eb 7 19	9. Birthplace (State or Foreign Country) 18 Maryland
	Maryland -f show lied at	tor	10a. State 10b. County 10c. City, Town MD Allegany LaVale			10d. Inside City Limits 1 ☐ Yes 3€ No
	h with the 23a or 28a st be noti	Funeral Director	10e. Street and Number 230 S. First Street	10f. Zip Code 21502	10g.	Citizen of What Country?
9036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural; or iteme 23s or 28s-f show other treumatic event, the Medical Examinat must be notified at	þ	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Amed Forces?  1 Never Married 2 No. 1942  1 Yes, Give Year or Dates: 1945	13. Was Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto R	ify Yes or No- ican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
Maryland 21215-0036	filed withln 72 h Hygiene. wher than "natu ant, me Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Sales	Pl	. Kind of Business/Industry umbing & Heating
yland	2 should be file and Mental Hy Is marked oth eumatic event	To Be (	17. Father's Name (First, Middle, Last) Charles Ward Rosenmarkle	18. Mother's Name Clara Is	(First, Middle, Maid sabelle	den Sumame) Diggs
	1 and 2 sho Health and tem 27 is my		Mary Shoemaker Daughter 2	Mailing Address (Street and Number or Rural 30 S. First St., I	aVale,	MD 21502
Baltimore,	permit. Pages 1 Department of H Importent: If iter any injury or oth		1 Rurial 2 Comption 2 Demouslifrom State Cemeter	Disposition (Name of y, crematory or other place)  ugh Crematory Mar	18 2005	
Balt	Depart Depart Import any in		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Haf 1302 National Hw	y., LaV	
	Pnysician /Medical		23a. Part 1. Enter the disease, or completations that caused the death. Do r shock, or heart failure. List only the cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Aspiration pneu Due to (or as a consequence of the consequence of the cause	monia	respiratory arrest,	Approximate Interval Batween Onset and Death 2 days
	Examiner	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or might)	of):		
68760, 4	death certificate be executed e attending physician and ad for use as the burial-transit	dicai Examiner	that initiated avents resulting in death) Last  C. Due to (or as a consequence of d.	of):		
.O. Box	that the death certificat led by the attending phy detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
rds, P	quires that n signed b uld be deta		Part II. Other significant conditions contributing to death but not resulting in Neurodegenerative disorder	the underlying cause given in Part I.	23e. Did tobaco	2 No 3 Probably 4 Unknown
I Records,	The law requires that the rate has been signed by the page 2 should be detached.	Completed by			24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	26. Place of Death		
of	Phys this ral di	on: To	27. Manner of Death 28a. Date of Injury 28b. T	tpatient 3 DOA 4 Nursing Hom	e 5 Residence  3d. Describe how in	o 6 ☐Other (Specify)
Division	deatl deatl stor:	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No  rm, street, factory, office 28	Bf. Location (Street City or Town, St	and Number or Rural Route Number, ate)
	To the Hospitel or Attence within 24 hours after death To the Funerel Director: completely filled in by the	Medical Ce	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination and and manner stated.	, death occurred at the time, date and place, an Mor investigation, in my opinion, death occurred	nd due to the cause d at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
)	To th withir To th comp	M	29b. Signature and title of certifier  Che Hopker Vagneri Mr.	29c. License number D0059987		Date signed (Month, Day, Year)
	241		30. Name and address of person who completed cause of death (Item 23a) (Christopher Vagnoni M.D. 600 Memo	Type, Print) rial Avenue Cumberlan	d, Maryl	and 21502
	Sta Registr	- 4	31. Date filed (Month, Day, Year)  MAR 2 5 2005	barle		

			For State	State	of Maryland /		rtment of F		Mental Hy	_		
			Registrer  1. Decedent's Name (First, Middle	a. Last)		001	incate of	Dealii	2. Date of D	Reg. No eath	2005	3. Time of Death
	Physici								Month March	Da	y Year	11:50a <sup>M</sup>
	/Medic		Alberta 4a. Facility Name (If not institution		seur		4b. City, Town, o	r Location of De			County of Death	
	Examin	er	Larkin Chase				Bowie	. 2004.011 01 20				Georges
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. last b	oirthday)	If Under 1 Year	If Under 24 H		dh	O. Diet	place (State or Foreign
	Director		579-24-1696	1 □ M 2 🔀 F	89	Yrs.	Months Days	Hours Mi				intry) S • C •
	pr ,		Usual Residence of Decedent		10.00.7							
	show	_	10a. State 10b. County		10c. City, To							10d. Inside City Limits
	8e-f	Director	Md. P.	G.	Ten	nple	Hills					1 X Yes 2 No
	with ti	Dir	10e. Street and Number				10f. Zip Code			10g. Cit	tizen of What Cou	untry?
	s 23	rai	4904 Braddoo		cedent Ever in U.S.	10.11		748	/O 7 14 11		United	
_	filed within 72 hours after death with the Maryland Hygiene. ther then "neturel", or Items 23a or 28e-f show inter then "neturel", or Items 7 must be notified at	Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Marri	Armed F		I3. V	Yes, specify Cub	an, Mexican, Pu	(Specify Yes or N erto Rican, etc.)	0-	14. Race - Amer Black, White	
2	irs af	by F	3 ☐ Widowed 4 ☑ Divorced	If Yes, G	ive	1	☐ Yes 2 No	Specify:			Specify: Bla	ack
5	2 hou	ted	15. Deceden		16	a. Deced	ent's Usual Occup	ation		16b. K	ind of Business/l	
7	hin 7.	Completed	(Specify only higher Elementary/Secondary (0-12)		(1-4or 5+)	(Give I life. D	kind of work done OO NOT use retire	during most of w d)	orking			
V	d wit giene er the	mo.	6	00,1090	(1. 40, 01)	Exa	aminer			Bu	reau of	Engravin
	e file al Hy othe vent.	Be (	17. Father's Name (First, Middle,	Last)				18. Mother's N	ame (First, Middle	e, Maider	Sumame)	
<u>a</u>	uld b Ments rrked rtic e	10	Henry Jones					Lula	Stradfo	rd		
2	2 sho and 1 s ms		19a. Informant's Name/Relations		19	b. Mailin	Address (Street	and Number or	Rural Route Numi	ber, City	or Town, State, Z	ip Code)
2	and and not not not not not not not not not not		Luetta Cooper	/daught	er †	emp.	Braddo le Hill	s,Md.	20748			
9	of Ho		20a. Method of Disposition  12 Burial 2 Cremation	3 Removal from	20b. Place cemet	of Dispos tery, crem	sition (Name of natory or other place	сө)	Date	20c. L	ocation · City or T	own, State
Ē	Pag ment ent: l		'4 □Donation 5 □ Other (S		Harm	ony	Mem. P	ark 3/	10/05	Laı	ndover,	Md.
paritino	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel; or items 23a or 28e-f show any injury or other traumatic event, the Madical Examinat must be notified at ODGe.		21. Signature of Funeral Service	Liconsop					Hodges			
_	<u></u>		yanue	Cour	ies						land, M	D.20746
			23a. Part . Enter the disease, or hock, or heart failure. List	complications that only one cause on	caused the death. Do each line.	o not ente	er the mode of dyir	ng, such as card	ac or respiratory a	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	. AR	TERIO SC	LER	OTIC (	ARDIO	VAS CUL	AR	DISTAGE	Onset and Death
	/Medical Examiner		resulting in death)	Due to	(or as a consequence							
	Lammer		Sequentially list conditions,	b								
	ait sit	iner	Tany, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due 10	(or as a consequenc	a ory						
_	and A-tran	Examin	that initiated events resulting in death) Last	c	(or as a consequence	e of)-						
200	icate be executed physician and the burial-transit	a m				,-						
200		edicai		d		-						
XOD	certi nding use a	/W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, or	utcome of pregnancy						23d. Date of delik	/ADV
Ď	death a atte d for	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☑ No		birth 2 ☐ Fetal dea jnant at time of death		Ectopic pregnancy Other (specify) _	4			Month	Day Year
ġ	the cy by the	hys	9 Unknown	9□ Unk	nown							
7	law requires that the death certific as been signed by the attending p 2 should be detached for use as	by P	Part II. Other significant condition	ons contributing to				en in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
cords	w require been sig should b		CONGESTIVE	HEA	ST FAIL	UR	E		10	Yes 2	□No 3 □ Pro	babiy 4 🗗 Unknown
0	sw requ s been s shoulk	Completed	DEMENTIA						24a. Wa		24b. Were aut	opsy findings available
Ľ	9 4 9	E O								ormed?	death?	ompletion of cause of
VII	iicien: Th certificate rector, pag	0	25. Was case referred to medica					26. Place of D	1 ☐ Yes		1 □ Yes	2   NO
	Physicien: r this certific ral director,	0 B	examiner? 1 □ Yes 2 🗹 No	Hospital:	Inpatient 2 ER/C	Outpatien!	3 DOA Ott	00	Home 5□Res		6 □Other (Spec	ify)
O	ding Phys I. After this funeral di	i.i	27. Manner of Death	28a. Date	The state of the s	. Time of Injury	28c. Injui Wor		28d. Describe			.,,,
0	ath.	atio	1 ☑Natural 5 ☐ Pendir investi	gation	in, say rour,	injury		Yes 2 □ No				
DIVISION	r Atte er de recto by th	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ined 289. Plac	e of Injury - At home, ding, etc. (Specify)	farm, stre	et, factory, office		28f. Location City or To			al Route Number,
5	telonrs aft	Cer							Oily oil 10	, oluic	-7	
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	edicai	29a. Certifier 1 Certifyir (Check only 2 Medicel	g Physicien: To th	e best of my knowled basis of examination a	ge, death	occurred at the timestigation in my o	me, date and pla	ce, and due to the	cause(s	) and manner as	stated.
	the h	Med	one)	and ma	nner stated.							
	To To	~	29b. Signature and title of certifie	ATTE	NDING P	iNSU	29c. Licens	SO O O		29d. Da	te signed (Month	, Day, Year)
	151							2100		Mar	ch 7,	2005
_	(3)		30. Name and address of person MUSA MOM (	who completed car	use of death (Item 23a 8700 CEA	TRA	Print)	#301	LANDO	VER	, MD :	20785
	. Sta	ate	31. Date filed (Month, Day, Year)						•			,
	Registi		MAR 1 1 2	005	Registrar's Signature	Ano	E					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** Rhodes 2036 Rose Madeline MARCH 08 2005 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner CUMBERLAND MEMORIAL HOSPITAL ALLEGANY If Under 1 Year | If Under 24 Hrs. | Wonths Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** 1□M 2\F Months 82 Yrs. West Virginia 236-20-9677 10/19/1922 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10a. State 10b. County 10c. City. Town or Location 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Mineral Keyser Director 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 5 26726 USA Route 2 Box 142-B 23a death v Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Items 11. Marital Status within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 ò Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced natural 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) alth and Mental Hygiene. 27 Is marked other than "I r traumatic event, I'm Med Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Homemaker 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Gowans Mary Gibson Grady Alexander Clarence 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 Is any injury or other trau once. Route 2 Box 142-B, Keyser, West Virginia Houston Rhodes / husband Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 03/09/2005 Cumberland, MD Cumberland Crematory \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Alams Family Funeral Home, P.A. 21. Signature of Fun ral Service Licensee 404 Decatur Street, Cumberland, Maryland -alu 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEVERE EMPHYSEMA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner BILATERAL PNEUMONIA if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760, attending physician Physician/Medical as the t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery use 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? for 4□Pregnant at time of death 5 Other (specify) ed by the a P.O. 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. Completed by page 2 should be 3 ☐ Probably 4 Munknown 1 ☐ Yes 2 ☐ No peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate has 1 Yes 2 No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be funeral director, Cther: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death After Injury 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A 2 Accident the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide l in by determined 4 - Homicide filled 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified 2005 MARCH 09 D0060478 3 person who completed cause of death (Item 23a) (Type, Print) 30. Name and address CUMBERLAND, MARYLAND 21502 625 KENT SUITE 102 DR.AFAQ AHMAD AVENUE 1125 32. Resistrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

MAR 1 0 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) <sup>Day</sup> 2005 March 5, Year **Physician** 6:15 PM Rafferty /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Potomac Montgomery Warm Care of Potomac If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 X F 96 Yrs 13,1908 Ireland Director 577-70-5039 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f show adical Examinat must be notified at 1 ☐ Yes 2X No Potomac Montgomery Direct 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 10301 Gainsborough Road 20854 IISA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be filt.
Department of Health and Mental Hy
Important: If tiem 27 is marked oth
any injury or other traumatic event
2009. Brigid O'Halloran John Mahoney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vincent F. Rafferty - son 13829 Wisteria Drive Germantown, MD 20874 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Silver Spring, MD <sup>4</sup> □ Donation 5 □ Other (Specify) Gate of Heaven Cem. 3/11/2005 22. Name and Address of Facility DeVol Funeral Home 21 Signature of Funeral Service Licenses 10 East Deer Park Drive Gaithersburg, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) a Alzheimers Disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed use as the burial-tran attending physician and Due to (or as a consequence of): Physiclan/Medical d IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death in the past 12 months? 1 ☐ Yes 2X No Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ funeral director, page 2 should be 1 Yes 2 No 3 Probably 4 XUnknown Depression Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2【 No 24a. Was an Congestive Heart Failure certificate has autopsy 2**X** No 1 Yes Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$ Other (Specify) AssistedCertification: To 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 5 Pending after death. 1 Tyes 2 🗆 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1X Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the within 2 To the 29d. Date signed (Month, Dev. Year) 29b. Signature and title of certifier 29c. License number

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 1 2005

Loreto S. Albiol, M.D.,

31. Date filed (Month, Day, Year)

D 31319

8218 Wisconsin Ave., # 305, Bethesda, Maryland 20814

March 8, 2005

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) MARCH 8, Day **Physician** 2005 6:08 AM ROBINSON, SR ELWOOD C. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner MONTGOMERY Silver Spring Holy Cross Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Yeer) | May 29, 1936 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** M 2 F 68 Wash. Director 579-46-0670 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State or 28a-f show Examiner count by notified at XXYes 2 ☐ No MD Prince Geo. Laurel Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 20708 9403 Spring House Lane, #AU.S.A. death 14. Race - American Indian. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after inent of Heatth and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Iten ary or other tranmatic avent, the Medical Examinal 1 X Yes 2 ☐ No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 59-63 1 ☐ Yes 2√2 No Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 5 yrs Elementary/Secondary (0-12) U.S. Customs Customs Inpector 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Mary Hinton Lewis E. Robinson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Eleanor Robinson (Wife) 9403 Spring House Ln, #A, Laurel, MD 20708 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Buria 1 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or Ouantico Nat'l Cem 3/15/05 Triangle, VA \* 4 □ Donetion 5 □ Other (Specify) 22. Name and Address of Facility Snowden Funeral Home, P.A. 21. Sign sure it Funeral Service License 246 N. Wash. ST., Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do hot enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Possible Myocardial Infarction /Medical Due to (or as a consequence of) Examiner Pneumonia Securation of the cause if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed Left CAV with Right Hemisle ia Due to (or as a consequence of) Box 68760. nding physician Physician/Medical Diabetes Mellitus as the b IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate 2 No 1 Yes 1 Yes 2 **T**No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No M☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funerai 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28h Time of 28d. Describe how injury occurred After 5 Pending investigation 1 Natural after death. I Director: Af id in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified Mar. 8, 2005 D20274 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kirti Vohra, M.D. 7710 Bradley Blvd, Bethesda, MD 20817

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

1 1 2005

			For State Registrar	State of	Maryland / Dep	partment of Fertificate of			gienez 0 0 E	5 10342
	Physici	an	Decedent's Name (First, Middle	-210-10				2. Date of Dea Month March	Day Year	T . 1.4
private and	/Medic Examin		Katherine \ 4a. Facility Name (If not institution			4b. City, Town, o	r Location of De		4c. County of De	
			Clearview No. 5. Social Security Number		e . Age (In yrs. last birthda		erstown If Under 24 H			nington inthplace (State or Foreign country)
	Funeral Director		220-18-1884	1□M 2 <b>X</b> XF	96 Yrs.	Months Days	Hours M	Sept.7,	1908	Mary Land
	rland row		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	8a-feh	ctor		ington	1	Villiamspo	rt		40 000	1 □ Yes 2XXVo
	3a or 2	Funeral Director	10e. Street and Number 15103 Clear S	Spring Road	d	10f. Zip Code	21795		10g. Citizen of What C	
	r deeth	unera	11. Marital Status	12. Was Deced Armed Ford	ent Ever in U.S. 13	3. Was Decedent of H If Yes, specify Cubi	lispanic Origin? an, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - Arr Black, Wh	
036	be filed within 72 hours efter deeth with the Maryland Ital Hygiene. ed other than "natural", or items 23a or 28s-f ehow event, Ita Medical Examinat must be notified at	by Fi	1 ☐ Never Married 2 ☐ Marr 3 ☐ Widowed 4 ☐ Divorced	ied 1 □ Yes 2 If Yes, Give Year or Dat	1	1 ☐ Yes 2 💢 No	Specify:		Specify:	White
5-0	"natur	Completed by	15. Decedent (Specify only highes	's Education it grade completed)	(Gi	edent's Usual Occup re kind of work done DO NOT use retired	during most of v	vorking	16b. Kind of Busines	s/Industry
212	led within lygiene. her than "	фшо	Elementary/Secondary (0-12)	College (1-4	for 5+)	Quiller	,		Garment Ma	nufacturer
Maryland 21215-0036	be file ntal Hy of othe event,	Be	17. Father's Name (First, Middle,	Last)				lame (First, Middle,		
aryli	should be tnd Mental marked umatic ev	၉	Otho W. Domer  19a. Informant's Name/Relations	hip (Type, Print)	19b. Ma	iling Address (Street			eth Sweer r, City or Town, State,	
Š	s 1 and 2 should f Health and Mer item 27 is marks other traumatic		Ralph Staley -	Grandson				Rd. Willi	amsport, Ma	aryland 21795
Mor	Pages ment of than to the mant: if ite		1 ☑ Burial 2 ☐ Cremation  1 ☑ Donation 5 ☐ Other (S)		ale	position (Name of rematory or other place on Mom Par	!	17 2005		ort.Maryland
Baltimore,	permit. I Departm Importa any inju		21. Signature of Juneral Service	1991		33884 Me 446	meFaily H	ome, P.A.		0-10-10-10-10-10-10-10-10-10-10-10-10-10
	20 E e d		23a. Part1. Enter the disease, or	complications that cau	used the death. Do not e				illiamspor rest,	+,MD 21795 Approximate
4	Physician		shock, or heart failure. List Immediate Cause (Final disease or condition	only one cause on eac	meethe	Heart	Fail	we		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or	r as a consequence of):	2 (2	1 1 2 1 -	seulo	Aureno	
	ъ ≃	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (o	r as a consequence of):	ue o	-CHOE		00000	
	sician end burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	r as a consequence of):					
8760,	ate be ex hysician the burial	Ca C		d						
9	death certificate e ettending phys d for use as the	/Med	IF FEMALE: 23b. Was decedent pregnant		ome of pregnancy	41			23d. Date of d	elivery
P.O. Box	that the death ned by the etter detached for u	Physician/Med	in the past 12 months?  1 Yes 2 No 9 Unknown		nt at time of death	B⊟Ectopic pregnancy  □ Other (specify) _	<u>'</u>		Month	Day Year
	% 5° 6	2	Part II. Other significant condition	ons contributing to dea	th but not resulting in the	underlying cause giv	en in Part I.	23e. Did to		to the cause of death?  Probably 4 □Unknown
Records,	w require been sly should b	leted	Jup	ellous	Draw	en		24a. Was a		aulopsy findings available completion of cause of
Re	The ete h	Completed	——————————————————————————————————————					autop: perfor	mpd?   death?	completion of cause of
Vital	sicien: certific rector,	o Be (	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	patient 2 ER/Outpat	ient 3□ DOA Oth		Death (Check only or	n <i>e)</i> ence 6 □Other <i>(Sp</i>	ogića)
of	ng Phya ter this neral di	11-1	27. Manner of Death  1 Natural 5 Pendin	28a. Date of		of 28c. Injur	y at k?		ow injury occurred	волу)
Division	Attending r death. sctor: After by the fune	Catic	2 Accident investig	not be 290 Place o	of Injury - At home, farm,		Yes 2 □ No		treet and Number or F	Rural Route Number,
Ω	tel or A	Certification;	4 Homicide determ		g, etc. (Specify)			City or Tow	n, State)	
	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	Medical	29a. Certifier   1 Certifyin   2 Medical	g Physician: To the b Examiner: On the bas and manne	est of my knowledge, de sis of examination and/or er stated.	ath occurred at the til investigation, in my o	me, date and pla ppinion, death oc	ice, and due to the control at the time, control at the time, control	ause(s) and manner a late and place, and du	as stated. ue to the cause(s)
	withir To th	W	29b. Signature and title of certifie	7.1	D	29c. Lireos	e number	10	29d. Date signed (Mor	nth, Day, Year)
•			30. Name and address of person	who completed cause	of death (Item 23a) (Typ	e, Print)	1100		J1. 11.00	
ع	H-1		Gloria Pura,	M.D. 366 I	Mill Street	Hagersto	own, Mar	yland 21	740	
	Sta Regist		31. Date filed (Month, Day, Year)	5 2005	been J.	Level 1				

			1 - State Registrar	State of Ma	•	partment <i>ertificate</i>				giene Reg. No		
			Registrar     Decedent's Name (First, Middle, Last)						2. Date of De	ath	2005	3. Time of Death
~ ~	Physici		WILLIAM L. RUHL						Month	Day 13	2005	3045M
3	/Medic		4a. Facility Name (If not institution, give st	treet and number)	10/10	4b. City, T	own, or Lo	cation of Deat			County of Deat	h •
4			PONIBULA KEGILANDI	Medical	CENTU		30115	bly	(B)		WICOM	• • • • • • • • • • • • • • • • • • • •
5	Funeral		5. Social Security Number 6. Sex	7. Age	e (In yrs. last birtho 82 Yrs	Months		Under 24 Hrs Hours Min		h y Year) Q 2 3	Co	hplace (State or Foreign untry) IMORE, MD.
00	Director		Usual Residence of Decedent		02				02-00-1	723	DAGI	THORE, THE
1	yland now		10a. State 10b. County		10c. City, Town o	r Location						10d. Inside City Limits
V	Mar a-1st	ctor	MD WICOMIC	0	SALISBU	RY						1√7 Yes 2 No
ñ	ith the	Director	10e. Street and Number			10f. Zip (				10g. Cit	izen of What Co	untry?
#	ath w	rai	317 N. PARK DRIVE	n 144 - David - 1	5	12 14/22 Dane	2180		Sandy Van as No		USA 14. Race - Ame	ocan Indian
M	ter de Items	Funerai	11. Marital Status 1 1 ☐ Never Married 2 Married	2. Was Decedent E Armed Forces? 1 ∑Yes 2 □ N		If Yes, speci	fy Cuban,	Mexican, Puer	Specify Yes or No to Rican, etc.)		Black, White	
N	1036  Ours after death with the Marylar rat', or Items 23a or 28a-1 show Exartirer must be rutified at	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1945-	1 ☐ Yes 2	⊠ No .	Specify:			Specify: W	HITE
	1215-0036 within 72 hours after death with the Maryland ene. Then "natural", or items 23a or 28a-1 show to Maryles I show to Maryles I show to Maryles I show to Maryles I show to Maryles I show to Maryles I show to Maryles I show to Maryles I show to Maryles I show to Maryles I show the Maryles I	Completed	15. Decedent's Educ (Specify only highest grade		16a. D	ecedent's Usual Give kind of work	Occupation of the contract of	on ing most of wo	orking	16b. K	ind of Business/	Industry
-	Aithin ne.	mpie	Elementary/Secondary (0-12)	College (1-4or 5	(i+)	fe. <i>DO NOT</i> usi ENERAL	e retired)			HO	TEL CHAI	N
7	121 Hygier Ther ti		10 17. Father's Name (First, Middle, Last)			ENEIGHD			me (First, Middle,			
X	and d be f antal h ced of	To Be	WILLIAM L. RUHL, S	R.			1		L. LARK		,	
:	Maryland 2121! d 2 should be filed within 7 h and Mental Hygienal 7 is marked other than "r traumatic avent, 11 a Max	۳	19a. Informant's Name/Relationship (Typ	oe, Print)	19b. N	failing Address	(Street and	d Number or A	ural Route Numbe	er, City o	or Town, State, Z	Zip Code)
44	Mc 2 alth a alth a 127 is		EDITH M. RUHL - SP	OUSE	317	N. PAR	K DR	IVE, SAL	ISBURY,	MAR	YLAND 21	804
an	of He		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Re	emoval from State		crematory or ot	her place)		Date		ocation - City or	
10	Pag ment tent: I		`4 □ Donation 5 □ Other (Specify)		CREMATO				15-2005			
	Baltimore, Maryland 21215-0 permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturany injury or other traumatic avent, It a Madical once.		21. Signature of Funeral Service License	la un					UNDS FUN			INC. AND 21804
3	40200		23a Lett Enter the disease or compli	cations that sused	I the death. Do no						XI , FIRXXI I	Approximate
2	PER S		23a. F. ft1. Enter the diseas or complik nock, or heart failur. List only on Immediate Cause (Final						, , , , ,			Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)		a consequence of)		1					1 MONTH
	Examiner	П	Sequentially list conditions		,							
	P #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or in jury) that jurited execute.		a consequence of)	:						
	ecuter and trans	Examiner	that initiated events cresulting in death) Last		a consequence of)							
	18760, cate be executed physician and the burial-transit			200 10 (01 03	a domodquomoc un	*						
	at at h	edicai	0									
	Box 6 eath certific attending p for use as	n/M	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome	of pregnancy 2   Fetal death	3 □Ectopic pre	anana.				23d. Date of del	
	death	by Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at		5 Other (spe					Month	Day Year
	P.O at the	Phys	9 Unknown					in Dani I	220 Did	obacca	usa aantributa ta	the cause of death?
	Division of Vital Records, P.O. Ior Attending Physician: The law requires that the dater death. Diractor: After this certificate has been signed by the tin by the tuneral director, page 2 should be detached.	by	Part II. Other significant conditions con	_	_	ne underlying ca	use given	іп Рап І.		/-		obably 4 Unknown
	requi	eted		1 2 2 1	,,				24a. Was		1	
	Rec ne law has l	Completed							auto	psy ormed?	prior to death?	stopsy findings available completion of cause of
	tall	e Co	25. Was case referred to medical					96 Place of De	1 ☐ Yes eath (Check only o	2 No	1	2 No
	s cert	To B	evaminer?	lospital:	ent 2 ER/Outp	atient 3 DO	-		Home 5□ Resi		6 ☐Other (Spe	cify)
	og Phy g Phy ter thi	T:U	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da		ne of 2	3c. Injury a Work?		28d. Describe			
	endir eath. or: Af	catic	2 Accident investigation			М	1 🗌 Ye	s 2 No				
	or Att fter de diract	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inj building, et	ury - At home, farn c. <i>(Specify)</i>	n, street, factory	, office		28f. Location ( City or To			ural Route Number,
	Division of Vital Records, P.O. Box 66 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Diractor: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as:		29a. Certifier 1 Certifying Phys	Rician: To the best	of my knowledge.	death occurred	at the time	date and place	e, and due to the	cause(s	) and manner as	s stated.
	e Hos 24 h e Fur letely	Medical	(Check only 2 Medical Examination)		f examination and/							
	To th withir To th	Me	29b. Signature and title of certifier				. License r			è	ite signed (Mont	
	bad.		Rupale	-, M.	٥.	D	291	6 8		3/,	4/05	
	1. 3.		30. Name and address of person who co	impleted cause of c	death (Item 23a) (T	ype, Print)			_			
	. 6		ADBERT ALLE.  31. Date filed (Month, Day, Year)  MAR 1 4 20	22 Pariety	ar's Signature	6 5- 1	11/15	3~ 57	SALI	300	12-7 M	10 21804
	St Regist	ate	MAR 1 4 20	005	we K	bosele	,					

		For S	tate of Maryland / Depa <i>Cei</i>	artment of Health and N tificate of Death	ental Hygie/ Reg.	000-					
Physicia	n	Decedent's Name (First, Middle, Last)			2. Date of Death	Day Year 3 Time of Death					
/Medica Examine	al .	Louis Donald Sesta 4a. Facility Name (If not institution, give street CityZens Nills	et and number)	4b. City, Town, or Location of Death	March	4c. County of Death					
Funeral Director		5. Social Security Number 6. Sex 18 M	J 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	ear)  9. Birthplace (State or Foreign Country)  1918  Pennsylvania					
Maryland f show	or	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo			10d. Inside City Limits					
h with the ? :3a or 28e-	al Director	10e. Street and Number		10f. Zip Code		Citizen of What Country?					
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Importent: If item 27 is marked other than "natural", or Itams 23a or 28e-1 show any injury or other traumatic avant. Its Medical Evariation must be notified at once.	by Funeral	1 Never Married 2 Married	Armed Forces?	Nas Decedent of Hispanic Origin? (Sr 1 Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2X No Specify:	OCITY YES OF NO-	nited States American Indian, Black, White, etc.  Specify: White					
21215-0036 d within 72 hours all giene. er than "natural", or ure Medicul Evarial.	Completed t	15. Decedent's Education (Specify only highest grade co	on mpleted) 16a. Decer (Give life. i	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	sing 16t	b. Kind of Business/Industry					
and 21 the filed winter Hygien ted other th	Be	10 17. Father's Name (First, Middle, Last) Martin Sestak	M		e (First, Middle, Mai						
Maryland d 2 should be file the and Mental Hy 27 is marked oth traumatic avan	은	19a. Informant's Name/Relationship (Type,		ng Address (Street and Number or Ru	ral Route Number, C	ity or Town, State, Zip Code)					
more, N Pages 1 and nent of Health nt; If item 27 rry or other ti		20a. Wethod of Disposition  1 Burial 2X Cremation 3 Rem  4 Donation 5 Other (Specify)	oval from State	natory or other place)							
Baltimore, permit. Pages 1 a Department of Hac Importent: If item eny injury or othe ponce.		1. Signature of Funeral Service Licensee  22. Name and Address of Facility  22. Name and Address of Facility  23. Name and Address of Facility  24. Name and Address of Facility  25. Name and Address of Facility  26. Name and Address of Facility  27. Name and Address of Facility  28. Name and Address of Facility  29. Name and Address of Facility  20. Name and Address of Facility  21. Name and Address of Facility  22. Name and Address of Facility  23. Name and Address of Facility  24. Name and Address of Facility  25. Name and Address of Facility  26. Name and Address of Facility  27. Name and Address of Facility  28. Name and Address of Facility  29. Name and Address of Facility  20. Name and Address of Facility  21. Name and Address of Facility  22. Name and Address of Facility  23. Name and Address of Facility  24. Name and Address of Facility  25. Name and Address of Facility  26. Name and Address of Facility  26. Name and Address of Facility  27. Name and Address of Facility  28. Name and Address of Facility  29. Name and Address of Facility  20. Name and Address of Facility  20. Name and Address of Facility  20. Name and Address of Facility  20. Name and Address of Facility  27. Name and Address of Facility  28. Name and Address of Facility  29. Name and Address of Facility  20. Name and Address of Facility  20. Name and Address of Facility  20. Name and Address of Facility  20. Name and Address of Facility  20. Name and Address of Facility  20. Name and Address of Facility  20. Name and Address of Facility  20. Name and Address of Facility  20. Name and Address of Facility  21. Name and Address of Facility  22. Name and Address of Facility  23. Name and Address of Facility  24. Name and Address of Facility  25. Name and Address of Facility  26. Name and Address of Facility  26. Name and Address of Facility  27. Name and Address of Facility  28. Name and Address of Facility  28. Name and Address of Facility  28. Name and Address of Facility  28. Name and Address of Facility  28. Name and Address of Facility									
Pnysician /Medical Examiner		shock, or heart failure. List only one of Immediate Cause (Final disease or condition resulting in death)	ause on each line.	er the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death 5 - ACC 4/5					
18760, cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease of injury that initiated events resulting in death) Last	Due to (or as a consequence of):  Due to (or as a consequence of):								
Cords, P.O. Box 68  requires that the death certific been signed by the attending p should be detached for use as:	Completed by Physiclan/Mec	in the past 12 months?		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year					
rds, P	ed by PI	Part II. Other significant conditions contrib	and the second s	nderlying cause given in Part I.		co use contribute to the cause of death?					
I Reco	Complet				24a. Was an autopsy performed 1 Yes 2						
n of Vita ng Physician: uter this certific ineral director	To Be	e 6  □Other (Specify) injury occurred									
Divisio  To the Hospitel or Attendi within 24 hours after death. To the Funaral Diractor: A completely filled in by the fu	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, sto building, etc. (Specify)	eet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)					
na Hospi n 24 hour ne Funar letely fill	Medical		en: To the best of my knowledge, deat : On the basis of examination and/or in and manner stated.								
To th within To th	Me	29b. Signature and title of certifier	my	29c. License number		Date signed (Month, Day, Year) 시 나나 다					
SH 3+1		30. Name and address of person who comp	leted cause of death (Item 23a) (Type,		Delisau	mo 21078					
Sta Registr		31. Date filed (Month, Day, Year) MAK 10 200	leted cause of death (Item 23a) (Type,	perker							

Sestak, Louis

				State of Mary State Registrar		rtment of Health and I		Reg. No. 200	5 10315
		Physicia /Medic		1. Decedent's Name (First, Middle, Last)  Arthur Shapiro			2. Date of De March	7 Day 2005	3. Time of Death 9:38 A. M
		Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death	1	4c. County of Dea	ılh
				3310 N. Leisure World Blvd.,  5. Social Security Number 6. Sex 7. Age (In	# 908 yrs. last birthday)	Silver Spring If Under 1 Year   If Under 24 Hrs.	8. Date of Bir	Montgom	ery rthplace (State or Foreign
		Funeral Director		5. Social Security Number 6. Sex 7. Age (In 17. M 2 F	83 Yrs.	Months Days Hours Min.	Januar	v, Year) C	ountry) New York
			ļ	Usual Residence of Decedenl					
	arylar	show	2		c.City,Town or Loc Silver Sp:				10d. Inside City Limits 11 Yes 2 □ No
	the M	286-f	ecto	10e. Street and Number	1	10f. Zip Code		10g. Cilizen of What C	
	with	3a or		3310 N. Leisure World Blvd.,	# 908	20906		U. S. A.	,-
	death	me 2	nera	11. Marital Status 12. Was Decedent Ever Armed Forces?		/as Decedent of Hispanic Origin? (S Yes, specify Cuban, Mexican, Puert	pecify Yes or No	- 14. Race - Am Black, Wh	
	d 21215-0036 filed within 72 hours after death with the Maryland	ne. Ihan "natural", or Itame 23a or 28e-f show in Medicul Ezatri net mat be rediffied at	Completed by Funeral Director	1 Never Married 2 Married  1 Yes, Give  Year or Dates: W	Navy	☐ Yes 2 No Specify:	o rican, etc.)	Specify:	White
	5-0036 72 hours aft	atural cul Ex	edt	15. Decedent's Education	16a Decede	ent's Usual Occupation		16b. Kind of Business	s/Industry
4	215 Zi rid	Media Media	plet	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give k	ind of work done during most of wor O NOT use retired)	rking	Goddard Sp	ace Flight
We !	2121 ed within	other than	Соп	5+	Aero	space Scientist		Cente	r
· ·	Maryland	even	Be	17. Father's Name (First, Middle, Last)  Nathan Shapiro			ne <i>(First, Middl</i> e, Schatte	, Maiden Sumame) n	
ξ.	Nould S	nark mark	ို	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing	Address (Street and Number or Ru			Zip Code)
	ام ع ام ع	alth ar 27 is r treu		Harriet S. Shapiro - Wife	3310	N. Leisure World	Blvd.,		er Spring
3	ore,	₽ <b>= ₫</b>		ATT R Sit C DOWN Size C Down Street Chats		atory or other place)	Date	20c. Location - City o	r Town, Slate
SHE CALLY	Baltimore,	tment rent: If		`4 □Donation 5 □ Other (Specify)			0/2005	Olney, Ma	
2	Da bermin	Dep rtment of Health and Mental Hygier Importent: If Item 27 is marked other til any rijury or puher treumatic event. If and the control of t		21. Signature of Funeral Service Licenses  Sorrold C. Stattlern	<u>Éd</u> 10	Name and Address of Facility Ward Sagel Funer 91 Rockville Pik	al Direc e, Rocky	ction, Inc. ville, Mary	1and 20852
	Ph	ysician	X 11	23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition		r the mode of dying, such as cardiac noma of Lung	or respiratory a	rrest,	Approximate Interval Between Onset and Death 3 Months
	//	Medical caminer		resulting in death)  Due to (or as a co					8 Months
		ammer	7	Sequentially list conditions, if any, leading to immediate Due to (or as a co		isease to Brain			- Monetis
	nted	ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events					
	Ö,	hysicien and the burial-transit		resulting in death) Last Due to (or as a co	nsequence of):				
	8760,	physic the bu	dica	d			<del></del>		
1	Box 68	attending ph I for use as th	/Me	IF FEMALE: 23c. If yes, outcome of p	regnancy			23d. Date of de	alivery
1	ecords, P.O. Box 68760, law requires that the death certificate be executed	by the attentached for u	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	]Fetal death 3 🔲	Ectopic pregnancy Other (specify)		Month	Day Year
	Records, P	igned be de	þ	Part II. Other significant conditions contributing to death but no Remote History of Tobacco		derlying cause given in Part I.	1	obacco use contribute Yes 2 🗌 No 3 🗆 F	to the cause of death?
4	S Ne	as been si 2 should l	ompleted				24a. Was	an 24b. Were a	utopsy findings available completion of cause of
W	œ å	ate ha	Com				auto perfo 1 Tyes	ormed? death? 2 No 1 ☐ Ye	s 2 No
3	Vital	is certificate director, pag	Be (	25. Was case referred to medical examiner?			ath (Check only o		
13	P P	this aldi	To	1 Yes 2 ANO 1 Inpatient	2 ER/Outpatient	3 DOA 4 Nursing F		dence 6 Other (Spa	ecify)
)	<b>□</b> 8	th. : After s funer	ıtlon	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation  28a. Dale of Injury (Month, Day Ye	ear) Injury	Wark? M 1 ☐ Yes 2 ☐ No		,,	
de	Division I or Attending	after death. Director: A in by the fi	Certification:	2 Cuiside 6 Could not be	At home, farm, stre	et, faclory, office	28f. Location ( City or To	Street and Number or F wn, State)	Rural Route Number,
B	itel o	rs afte	Cert						
y	To the Hospitel	within 24 hours after deati To the Funerel Director: completely filled in by the	edical	29a. Certifier (Check only one)  Certifying Physician: To the best of m 2 Medical Examiner: On the basis of examiner and manner stated	amination and/or inv	occurred at the time, date and place estigation, in my opinion, death occurred.	e, and due to the urred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	Tot	withi To tl	Ž	29b. Signature and title of certifier		29c. License number		29d. Date signed (Mor	
	_	0		Jen & Sealins		D25210		March 9,	2003
	ſ,	~		30. Name and Adress I person who completed cause of death Jerry Seals, M. D. 10700 (	(Item 23a) (Type, F	Print)	Columbi	o Marylan	1 210//
				Jerry Sears, M. D. 10700 (	Marter D.	rive, Suite 200,	COLUMBI	a, maryram	1 21044

Decedent's Name (First, Middle, Last)  Pauline G. Shiple  Pauline G. Shiple  Facility Name (If not institution, give in institution, gi	street and number)  nt Center  7. Age (In yrs 85)  10c. Coundel  12. Was Decedent Ever in Amed Forces? 1 M 2 W 1 M 2 M 1 M 1 M 1 M 1 M 1 M 1 M 1 M 1 M	19b. Maili 19b. Maili 1813  Place of Dispocemetary, cre Kalas C	Months Days  ocation  7ater  10f. Zip Code 2103  Was Decedent of His If Yes, specify Cuban  1 Yes 2 Xiv  adent's Usual Occupat  a kind of work done du  DO NOT use relired)  Investigato  ing Address (Street ar  B Potomac I  consistion (Name of  amatory or other place  Crematory  22. Name and Address	Jocation of Death  If Under 24 Hrs. Hours Min.  37  Panic Origin? (Spe, Mexican, Puerto for Specify:  18. Mother's Name Paul And Number or Rura Rd., Edge 3 1 3 1 9 1 9 1 9 1 9 1 9 1 9 1 9 1 9 1	8. Date of Birth (Month, Day, 4-10-1)  cify Yes or No- Rican, etc.)  (First, Middle, I ine St. I Route Number water, ate 05	Day Year 8, 2005  4c. County of D Anne Ar  Year) 9.  919  Ve  Og. Citizen of What  USA  14. Race - A Black, W Specify:  16b. Kind of Busine  State of Maiden Sumame)  Germain  To City or Town, State  MD 21037  20c. Location - City  Edgewater	Death rundel Birthplace (State or Fore Country) Permont  10d. Inside City Lim 1
rofton Convalesce Social Security Number 6. Sey 77-07-9991 1 2 3 3 3 3 3 3 3 3 3 3 3 3 3 4 3 3 3 3 3	The Center  7. Age (In yrs 85)  10c. Coundel  12. Was Decedent Ever in Amed Forces? 1  Yes 2  No If Yes, Give Year or Dates:  1. Cation (e completed)  College (1-4or 5+)  1. In the County of the Cou	Yrs.  City, Town or Lo  EdgeW  U.S. 13.  16a. Dece (Give life.)  19b. Maili 1813  Place of Disportantity, cre Kalas C 2: 2	Crofton  If Under 1 Year  Months Days  Ocation  Vater  10f. Zip Code 2103  Was Decedent of His If Yes, specify Cuban  1 Yes 2 (XNo  adent's Usual Occupate a kind of work done du DO NOT use retired)  Investigate  Consistion (Name of amatory or other place)  Crematory  22. Name and Address	If Under 24 Hrs. Hours Min.  37  panic Origin? (Spe, Mexican, Puerto Is Specify:  union tring most of working	(Month, Day, 4-10-1	Anne Ar  Year) 919  Og. Citizen of What  USA  14. Race - A Black, W Specify:  16b. Kind of Busine  State of Maiden Sumame)  Germain r, City or Town, Stat MD 21037  20c. Location - City  Edgewater	Birthplace (State or Fore Country)  10d. Inside City Lim 1 Yes 2XII  American Indian, White  ess/Industry  E Maryland  te, Zip Code)  y or Town, State
77-07-9991  Sual Residence of Decedent  a. State 10b. County  aryland Anne Ar  be. Street and Number  1813 Potomac Road  Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  15. Decedent's Edu (Specify only highest grad  Elementary/Secondary (0-12)  10th  7. Father's Name (First, Middle, Last)  Francis Vartu  9a. Informant's Name/Relationship (T)  ionroe S. Shipley,  10a. Method of Disposition  1 Burial 2 Cremation 3 F  1 Donation 5 Other (Specify)  1. Signatur of Juneral School Icens  1. Signatur of Juneral Sch	12. Was Decedent Ever in Armed Forces?  1 Yes, Give Year or Dates: (cation le completed)  College (1-4or 5+)  11  Type, Print)  IV/ Son  Removal from State	Yrs.  City, Town or Lo  EdgeW  U.S. 13.  16a. Dece (Give life.)  19b. Maili 1813  Place of Disportantity, cre Kalas C 2: 2	Months Days  ocation  vater  10f. Zip Code 2103  Was Decedent of His If Yes, specify Cuban  1 Yes 2 Xino  adent's Usual Occupat  a kind of work done du  DO NOT use relired)  Investigato  ing Address (Street ar  B Potomac I  consistion (Name of  amatory or other place  Crematory  22. Name and Address	Hours Min.  37  Panic Origin? (Spe, Mexican, Puerto for Specify:  Ition  18. Mother's Name  Paul  and Number or Rura  Rd., Edge  3-09-  s of Facility Geco	(Month, Day, 4-10-1	Og. Citizen of What  USA  14. Race - A Black, W Specify:  16b. Kind of Busine  State of Maiden Sumame)  Germain  F, City or Town, Stat  MD 21037  20c. Location - City  Edgewater	Ind. Inside City Lim  1 Yes 2XI  American Indian, White  Ess/Industry  Maryland  Ite, Zip Code)  y or Town, State
Anne Ar  e. Street and Number  1813 Potomac Road  Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  15. Decedent's Edu  (Specify only highest grad  Elementary/Secondary (0-12)  10th  7. Father's Name (First, Middle, Last)  Francis Vartu  9a. Informant's Name/Relationship (T)  ionroe S. Shipley,  10a. Method of Disposition  1 Burial 2 Cremation 3 F  4 Donation 5 Other (Specify)  1. Signatur of Juneral Secondary  2. Signatur of Juneral Secondary  2. Signatur of Juneral Secondary  3. Juneral Secondary  4. Signatur of Juneral Secondary  4. Signatur of Juneral Secondary  4. Signatur of Juneral Secondary  4. Signatur of Juneral Secondary  4. Signatur of Juneral Seconda	undel  12. Was Decedent Ever in Armed Forces?  1	Edgew U.S. 13.  16a. Dece (Give life.)  19b. Maili 1813  Place of Dispocemetary, cre Kalas C	Was Decedent of His If Yes, specify Cuban  1 Yes 2 No  addent's Usual Occupate to kind of work done of the DO NOT use retired)  Investigato  ing Address (Street ar B Potomac I Position (Name of amatory or other place Crematory)  22. Name and Address	panic Origin? (Spe, Mexican, Puerto for Specify:  Ition  Iting most of working the Month of the	city Yes or No-Rican, etc.)  ag  (First, Middle, I ine St. I Route Number water, ate	USA  14. Race - A Black, W Specify:  16b. Kind of Busine  State of Maiden Sumame)  Germain r, City or Town, Stat MD 21037  20c. Location - City  Edgewater	1   Yes 2XII  American Indian, White, etc.  White  Bess/Industry  E Maryland  Ite, Zip Code)  Y or Town, State
Da. Method of Disposition  1 Burial 2 Cremation 3 F  4 Donation 5 Other (Specify)  1. Signature of uneral Section of the secti	IV/ Son  Removal from State  Pee  Ilications that caused the de	1813 Place of Dispo cometery, cre. Kalas C	B Potomac I  cosition (Name of ematory or other place)  Crematory  22. Name and Address	Rd., Edge 3-09- s of Facility Geo	water, i	MD 21037 20c. Location - City Edgewater	y or Town, State
shock, or heart failure. List only o mmediate Cause (Final isease or condition	lications that caused the de ne causn ach line. a	ath. Do not en			d Rd.,	Edgewater	Approximate
any, leading to immediate ause. Enter Underlying cause (Disease or injury	b. Due to (or as a consect.  Due to (or as a consect.  Due to (or as a consect.)	equence of):	much	e Pu	lencer	cy Des	Interval Batween Onset and Death
FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▷ No 9 □ Unknown	23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	etal death 3[	□Ectopic pregnancy □ Other (specify)			23d. Date of Month	f delivery Day Year
art II. Other significant conditions co Delice fra General	ontributing to death but not r	esulting in the u	underlying cause give	n in Part I.	1 □ Yo 24a. Was a autops perfori	es 2 No 3 an 24b. Wern prior med?	Probably 4 Unknown authors availar to completion of cause th?
7. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)  28e. Place of Injury - At	28b. Time of Injury	of 28c. Injury Work  M 1 7 Y	at ? es 2 \( \text{No} \)	n (Check only or me 5 ☐ Reside 28d. Describe he 28f. Location (S	ence 6 Other (ow injury occurred	
(Check only one) Medical Exam	completed cause of death (II	tem 23a) (Type	29c. License	inion, death occurr	ed at the time, d	iate and place, and	due to the cause(s)
77	. Was case referred to medical examiner?    Was case referred to medical examiner.   Was case referred to medical examiner.	it II. Other significant conditions contributing to death but not respect to the conditions contributing to death but not respect to the conditions contributing to death but not respect to the conditions contributing to death but not respect to the conditions contributing to death but not respect to the conditions contributing to death but not respect to the conditions contributing to death but not respect to the conditions contributing to death but not respect to the conditions contributing to death but not respect to the conditions contributing to death but not respect to the conditions contributing to death but not respect to the conditions contributing to death but not respect to the conditions contributing to death but not respect to the conditions contributing to death but not respect to the conditions contributions contributing to death but not respect to the conditions conditions contributing to death but not respect to the conditions contributing to death but not respect to the conditions contributing to death but not respect to the conditions conditions contributing to death but not respect to the conditions conditio	it II. Other significant conditions contributing to death but not resulting in the significant conditions contributing to death but not resulting in the significant conditions contributing to death but not resulting in the significant conditions contributing to death but not resulting in the significant conditions contributing to death but not resulting in the significant conditions contributing to death but not resulting in the significant conditions contributing to death but not resulting in the significant conditions contributing to death but not resulting in the significant conditions contributing to death but not resulting in the significant conditions contributing to death but not resulting in the significant conditions contributing to death but not resulting in the significant conditions contributing to death but not resulting in the significant conditions contributing to death but not resulting in the significant conditions contributing to death but not resulting in the significant conditions contributing to death but not resulting in the significant conditions contributing to death but not resulting in the significant conditions contributing to death but not resulting in the significant conditions contributing to death but not resulting in the significant conditions co	The significant conditions contributing to death but not resulting in the underlying cause give states of person who completed cause of death (Item 23a) (Type, Print)  It. Other significant conditions contributing to death but not resulting in the underlying cause give states of th	It II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Collection	At II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did to Deliver Co.  24a. Was a autop permitted and permitted and permitted and permitted at the time, date and place, and due to the conditions of person who completed cause of death (Item 23a) (Type, Print)  25e. Did to Deliver Co.  26e. Place of Death (Check only or permitted at the time, date and place, and due to the conditions of person who completed cause of death (Item 23a) (Type, Print)  25e. Did to Deliver Co.  26e. Place of Death (Check only or permitted at the time, date and place, and due to the conditions of person who completed cause of death (Item 23a) (Type, Print)  25e. Did to Deliver Co.  26e. Place of Death (Check only or other)  27e. License number  28e. Did to Deliver Co.  28e. Did to Deliver Co.  28e. Did to Deliver Co.  28e. Place of Injury At home, farm, street, factory, office  28e. Place of Injury At home, farm, street, factory, office  28e. Did to Deliver Co.	The significant conditions contributing to death but not resulting in the underlying cause given in Part I.    1

DHMH 17 Rev 1/2001

Registrar

			1 - For State Registrar	State of Mary		irtment of He <i>tificate of D</i> e			C. U U U	0348
			Decedent's Name (First, Middle, Last	)		imodio or Di		2. Date of Dea	eg. No.	3. Time of Death
	Physici		Freda	Mae	Show	alter	1	March	13, 2005	i O a - C A u
	/Medic		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or Lo	ocation of Death	viki Cr	4c. County of De	
			Lions Manor Nur	sing Home		Cumb	erland		A1	legany
	Funeral		Social Security Number     6. Se	_ XZ	yrs. last birthday)		f Under 24 Hrs. Hours Min.	8. Date of Birth	Q B	rthplace (State or Foreign
i	Director		Usual Residence of Decedent	3M 2MF 82	Yrs.			(Month, Day, 02/22/1	923 Ma	ryland
	land ow		10a. State 10b. County	100	c. City, Town or Lo	cation				10d. Inside City Limits
	Mary -f sh	ğ	MD Alleg	any	Cumbe	rland				1∭ Yes 2 □ No
-	n the	<u>se</u>	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What C	country?
2	th wit	a D	537 N. Centr	e Street		2	1502		USA	
reda	III (A F I X 13-UU30  be filed within 72 hours after death with the Maryland ttal Hygiene.  do other than "natural", or Items 23a or 28a-i show event, I're Midical Examiner rust be notified at	Funeral Director	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13. V	Vas Decedent of Hisp Yes, specify Cuban,	anic Origin? (Spec	cify Yes or No-	14. Race - Am Black, Wh	
7 8	s afte	by Fu	1 Never Married 2 Married 3 Widowed 4 XDivorced	1 ☐ Yes 2 ☒ No If Yes, Give			Specify:	,	Specify:	
ع تې	tural E	ed b		Year or Dates:	16a Deced	ent's Heust Occupation	20		16b. Kind of Busines	White
工	0 7 in 7 in 10 in	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		(Give	ent's Usual Occupation kind of work done duri O NOT use retired)	ing most of working	g	TOD. KING OF BUSINESS	s/industry
_ 2	ful Z IZ e filed withi II Hygiene. other then vent, the M	ĕ	10	College (1-4or 5+)		Homemaker			Homemake	r
7	be file tal Hy od oth	Be (	17. Father's Name (First, Middle, Last)			18	3. Mother's Name	(First, Middle, M	Maiden Sumame)	
howalder	Addrylath	၉			Johns		Esther			rewnoski
3	VICIT 12 sh h and 7 is m traum	11 1	19a. Informant's Name/Relationship (T)	,					City or Town, State,	Zip Code)
3	ore, INI		George B. Showal		22/69 Db. Place of Dispos	Babbie Road	Andalusia Da		a 36420 20c. Location - City o	Taum Chata
2	ages nt of t: if it		1 XBurial 2 ☐ Cremation 3 ☐ F	temoval from State	cemetery, cren	atory or other place) morial Par	1			
7	Dallinore, invaryiation permit. Pages 1 and 2 should be file Oppartment of Health and Mental Hymportant: if Item 27 is marked oth any injury or other traumatic event once.		<ul> <li>4 □ Donation 5 □ Other (Specify)</li> <li>21. Signatur, of Fi neral Service Licens</li> </ul>						Cumberla ly Funera	I Home, P.A.
() a	Dalli permit. Departn Importa any inju		Holut C.	John .	1				berland,	
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only o	cations that caused the	eath. Do not ente	r the mode of dying, s	such as cardiac or	respiratory arre	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Parmary	Brain	Lynn	nom a			Onset and Death
	/Medical Examiner		resulting in death)	Due to or as a con	sequence of):		lisos de			111-
		er	Sequentially list conditions, if any, leading to immediate	Due to (or as a con	sequence of):		170€ CA	Λ		UR
	uted d ansit	Examiner	Sequentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		,,					
-	be executed ician and burial-transit	Exa	resulting in death) Last	Due to (or as a con	sequence of);					
68760	rificate be executed og physician and as the burial-transit	edical		l						
			IF FEMALE:	a. V.						
а >	attenc for us	:lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F	Fetal death 3 🗌	Ectopic pregnancy			23d. Date of de Month	livery Day Year
C	The law requires that the death certie has been signed by the attendin	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□ Pregnant at time 9□ Unknown	of death 5∐	Other (specify)			, indian	July 10a.
	s that	by Ph	Part II. Other significant conditions cor				n Part I.	23e. Did tob	acco use contribute to	o the cause of death?
200	quire;		DEEP	Year th	nombo	216		1 🗌 Ye	s 2□No 3□P	robably 4 Unknown
Ş	aw re	plet	Pulmon	asy En	nbolisi	η.		24a. Was an		utopsy findings available
Division of Vital Becords	ician: The lav certificate has rector, page 2	Completed	Gastain	Lordes	Wendi	na		autopsy perform 1 Yes 2	prior to	completion of cause of
<u>+</u>	shriffica	Bec	25. Was case referred to medical examiner?		-)   CEG(	26	6. Place of Death (			
<del>,</del>	Physician: this certific	၉	1 ☐ Yes 2 No		2 ER/Outpatient	3□ DOA Other:	4 Nursing Home	5 Reside	nce 6 Other (Spe	cify)
2	ding Phys	lon:	27. Manner of Death 1 ANatural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	r) 28b. Time of Injury	28c. Injury at Work?		d. Describe how	w injury occurred	
	death death ctor: / the	Certification:	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - A	At home form stro		2 No	E Logation (Str	eet and Number or R	-10
2	after Directory	ertii	4 Homicide determined	building, etc. (Sp.	ecify)	et, ractory, office	20	City or Town,	State)	urai Houte Number,
	To the Hospital or Attending Physician: The law requirements the hours after decided to the things the function of the function of the function by the funeral director, page 2 should be the funeral director, page 2 should		29a. Certifier Certifying Phys	ician: To the best of my	knowledge, death	occurred at the time, o	date and place, and	d due to the ca	use(s) and manner as	s stated.
	the Hin 24 the Ft	ledical	one) 2 Medical Examin	ner: On the basis of examand manner stated.	nination and/or inve	estigation, in my opinio	on, death occurred	at the time, da	te and place, and due	to the cause(s)
		Σ	29b. Signature and title of certifier	wed	_	29c. License nu		-	d. Date signed (Mont	h, Day, Year)
	3	-	, CHEN				6047	8 1	larch 14	, 2005
	nRs		30. Name and address of person who co	mpleted cause of death (	Item 23a) (Type, P	rint)	0 . 1.		1	
1	Sta	0	31. Date filed (Month, Day, Year)	3 Registrar's Si	do Ne	ILI MY.	Cum	serla	nd, MD	21502
	Registra	_	MAD 1 5 200	BASIL !	1. 600	September 1				

			1 - State of Maryland / Department of Health and N Certificate of Death		giene 005	10349
	Physic	an	1. Decedent's Name (First, Middle, Last)	2. Date of De		3. Time of Death
,	/Medi Examir	cal	Evan Leslie Smith, Jr.	03	4c. County of De	513:20
	Examir	ier	Sacred Heart Hospital Cumber	land	4c. County of De	2COU
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.  220 38 0664 1  M 2 F	8. Date of Birn (Month, Da	th 9. Bi	rthplace (State or Foreign
	Director		220-38-0664	11-Dec-		ryland
	anytan show	_	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	the M. 28a-f	Director	Maryland Allegany LaVale  10e. Street and Number 233 National Highways 10f. Zip Code		10= 0% (100 - 10	1 Yes 2 No
	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or Itams 23a or 28a-f show adother than "natural", or Itams 23a or 28a-f show avant. I're Modical Examirer must be notified at				10g. Citizen of What C	ountry?
	tams a	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No		
38	irs afte	by Fi			Specify:	ite, etc.
21215-0036	72 hou natura lical E				16b. Kind of Business	
121	vithin ne.	Completed	(Specify only highest grade completed)  (Give kind of work done during most of work life. DO NOT use retired)  Elementary/Secondary (0-12)  College (1-4or 5+)			
	filed v Hygie othar t	CO	12 maintenance engineer  17. Father's Name (First, Middle, Last)  18. Mother's Name		State Highwa	y Dept.
<u>'an</u>	should be ad Mental markad c matic ava	To Be			maiden Surrame)	
Maryland	E is		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Run	ral Route Numbe	er, City or Town, State,	Zip Code)
_	s 1 and if Health itam 27 other tra		Teresa Smith spouse 333 National Highway LaVa  20a. Method of Disposition (Name of	ale Date	Maryland	21502
altimore,	permit. Pages Department of I Important: If its any injury or or once.		1 ■Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place)		20c. Location - City of	
≣	partme portar y injur		^ 4 □ Donation 5 □ Other (Specify) Frostburg Memorial Park 15-N 21. Signature of Funeral Service Licensee 22. Name and Address of Facility	Mar-2005 F	rostourg	Maryland
מ	8 8 2 5 8		John K. Hurst Durst Funeral Home, 57 Fr	rost Ave.	Frostburg, M	D 21532
			23a. Pand. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of shock, or heart failure. List only one cause on each line.	or respiratory are	rest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. End-Stage Lung Carcinoma.  Due to (or as a consequence of):			1-2 years
	Examiner					
-	pe sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
	xecute al-tran	Examiner	that initiated events resulting in death) Last C.  Due to (or as a consequence of):			
0/00	cate be executed physician and the burial-transit	dicai E	d			
0	artifica ing ph e as th	Medi	IF FEMALE:			
YOO O	attend for use	lan/	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnancy		23d. Date of de Month	livery Day Year
	that the death cerifficed by the attending posterior detached for use as	Physician/Me	1  Yes 2 No 4 Pregnant at time of death 5 Other (specify) 9 Unknown			,
, L	w requires that the sbeen signed by the should be detach	by P	Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bacco use contribute to	the cause of death?
ecords,	requir	eted	COPD	1 🗆 Y	es 2 No 3 P	obably 4 Unknown
ב ב	has b	Completed		24a. Was a autops perfori	sy prior to	utopsy findings available completion of cause of
ונסו	ician: The lav certificate has rector, page 2:	Ø.	25. Was case referred to medical 26. Place of Death	1 ☐ Yes	2ENo 1□Yes	2 No
5	hysici his cer I direci	ToB	examiner?		ence 6 Other (Spe	cify)
	ling Phys n. After this funeral di		27. Manner of Death 1 Adural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work?		ow injury occurred	
131011	Attanc death octor: by the	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined country. At home, farm, street, factory, office 28e. Place of Injury. At home, farm, street, factory, office	28f Location (St	treet and Number or Ru	ural Pouto Number
Ē	tal or	Certi	4 Homicide determined building, etc. (Specify)	City or Town	n, State)	ar rioute rumber,
	To the Hospital or Attanding Physician: The law requires that the death certific within 24 hours after death: within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending is completely filled in by the funeral director, page 2 should be detached for use as	edicai (	29a. Certifier (Check only and)  2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, a continuous process of examination and/or investigation, in my opinion, death occurred at the time, date and place as the continuous process of examination and/or investigation, in my opinion, death occurred at the time, date and place, as the continuous process of examination and/or investigation, in my opinion, death occurred at the time, date and place, as the continuous process of examination and/or investigation, in my opinion, death occurred at the time, date and place, as the continuous process of examination and/or investigation, in my opinion, death occurred at the time, date and place, as the continuous process of examination and/or investigation, in my opinion, death occurred at the time, date and place and place are the continuous process.	and due to the cred at the time d	ause(s) and manner as	stated.
	o the ithin 2 o tha omplel	Med	one) and manner stated.  29b. Signature and title of certifier 29c. License number		9d. Date signed (Month	
	10					
			30. Name and address otherson who completed gause of death (Item 23a) (Type, Print)		3-11-05 1,MD 21	
	11-65		Christopher Vacanoni MD 900 Seton Drive Cun 31. Date filed (Mohth, Day, Year)	mberlen	1, MD 21	502
	Sta Registra		31. Date filed (Mohth, Day, Year)  MAR 1 4 2005  So Name and address byperson who completed dayse or death (Item 23a) (Type, Print)  Christopher Vacanoni MD 900 So ton Dove Cun  31. Date filed (Mohth, Day, Year)			

/Media	an cal	Decedent's Name (First, Mid Florence	Marie	Spelsho	ouse		2. Date of Deatl Month Var 7, 20	005 Year	3. Time of Deat
xamir		4a. Facility Name (If not instituti Country House	-		4b. City, Town, or Local Cumberlan	ation of Death		4c. County of Dea Allegany	th
ineral ector		5. Social Security Number 110-32-9607 Usual Residence of Decedent	6. Sex 1 □ M 2 💢 F	7. Age (In yrs. last birthda 98 Yrs.	Months Dave Ho	Jnder 24 Hrs. ours Min.	8. Date of Birth (Month, Day, Oct 21,		thplace (State or Fore ountry)
fed at	tor	10a. State 10b. Coun	egany	10c. City, Town or Cun	Location nberland				10d. Inside City Lin 1 □ Yes 2 □
st be not	ai Direc	10e. Street and Number 15 Cumberland	d Street		10f. Zip Code	502	10	0g. Citizen of What Co	ountry?
Important: If tem 27 is marked other than "natural, or tems 23s or 28s-1 show any injury or other treumstic event, It's Medical Examiner must be notified at once.	Completed by Funeral Director	11. Marital Status  1 Never Married 2 Ma 3 Xidowed 4 Divorce	Armed Fo	ve X No	3. Was Decedent of Hispan If Yes, specify Cuban, Me 1  Yes 2 No Sp	nic Origin? (Spe exican, Puerto f pecify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: Wh	te, etc.
rthan "natu Ibe Medical	ompietec	15. Decede (Specify only high Elementary/Secondary (0-12)	ent's Education lest grade completed)  College (1	(Gi	cedent's Usual Occupation ve kind of work done during b. DO NOT use retired)	g most of workir	)g	16b. Kind of Business	
arked othe atic event,	To Be C	17. Father's Name (First, Middle Frank Stelz	ə, Last)		18.			Maiden Sumame)	
or treum		19a. Informant's Name/Relation Nancy Nimmic		aughter 173	illing Address <i>(Street and N</i> 30 <b>Lynndale</b> R	Number or Rural	Route Number, Oaklar	City or Town, State, 2	Zip Code) MD 2155
ant: If Iten		20a. Method of Disposition  1 Burial 2 Teremation  4 Donation 5 Other (		State   20b. Place of Dis	position (Name of rematory or other place) uneral Home, P.	1	101000	Cresaptow	
dical		23a Part. Enter the disease, of Shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	or complications that can be stonly one cause on earEND	caused the death. Do not elect line.	enter the mode of dying, suc	Avenue; ch as cardiac or	Cumberla	and, MD 2150 st.	Approximate Interval Between Onset and Death 2 yrs
niner			Due to	(or as a consequence of):					2
the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Liner underlying Cause (Disease or injury that initiated events resulting in death) Last	C	(or as a consequence of):					
y the attending physician and ached for use as the burial-transit	icai	that initiated events	c	(or as a consequence of):  (or as a consequence of):  come of pregnancy inth 2 □ Fetal death 3 ant at time of death 5	s⊟Ectopic pregnancy □ Other (specify)			23d. Date of deli Month	
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hould be detached for use as	Completed by Physician/Medical	Lauss (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  Part II. Other significant condit	c	(or as a consequence of):  (or as a consequence of):  come of pregnancy inth 2   Fetal death 3 ant at time of death 5 bwn	□ Other (specify)underlying cause given in f		1 Yes  24a. Was an autopsy perform 1 Yes 2	Month  acco use contribute to   a 2 No 3 pro  24b. Were au  prior to coleat?  No 1 yes	ivery Day Year the cause of death obably 4 □Unknot topsy findings availate
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ineral director, page 2 should be detached for use as	Certification: To Be Completed by Physician/Medical	Lauss (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   2   No   9   Unknown  Part II. Other significant condit  25. Was case referred to medical examiner? 1   Yes   2   No   27. Manner of Death 1   Natural   5   Pendical examiner   28   Accident   1   No   3   Suicide   6   Could detern	c	(or as a consequence of):  (or as a consequence of):  come of pregnancy inth 2   Fetal death 3 ant at time of death 5 own  path but not resulting in the  Injury Injury   28b. Time Injury   28b. Time Injury Injury   28b. Time Inj	underlying cause given in factory, office	Place of Death  Nursing Hom 28 2 □ No	24a. Was an autopsy perform 1 Yes 2 (Check only one e 5 Residen ad. Describe how	Month  acco use contribute to s 2 No 3 □ Pro  24b. Were au prior to c death? 1 □ Yes  1 □ Yes  The contribute to to the contribute to the	ivery Day Year  the cause of death; obably 4 Unknot topsy findings availation of cause 2 No
ne constant become the continuate has been signed by the attention plately filled in by the funeral director, page 2 should be detached for use as	ertification: To Be Completed by Physician/Medical	Lauss (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   2   No   9   Unknown  Part II. Other significant condit  25. Was case referred to medical examiner? 1   Yes   2   No   27. Manner of Death 1   Natural   5   Pendian   29   Accident   Accident   3   Suicide   6   Could detent   29a. Certifier   1   Certifyi	c	(or as a consequence of):  (or as a consequence of):  come of pregnancy irth 2 Fetal death 3 ant at time of death 5 own  eath but not resulting in the  Injury Injury At home, farm, sing, etc. (Specify)  best of my knowledge, deasis of examination and/or income.	underlying cause given in final underlying cause given in fina	Place of Death  Nursing Hom  28 2 No  29  te and place, ar	24a. Was an autopsy perform 1 Yes 2 Check only one.  e 5 Residen ad. Describe how City or Town, and due to the caud at the time, date	Month  acco use contribute to s 2 No 3 produced?  24b. Were au prior to death?  No 1 Yes  Other (Spectard)  acco use contribute to to the prior to t	ivery Day Year  the cause of death? obably 4  Unknot toppy findings availa completion of cause 2  No city)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** MARCH 9. 2005 SHENKMAN а JOAN /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ROCKVILLE MONTGOMERY HEBREW HOME GREATER WASHINGTON If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year Birthplece (State or Foreign
Country) 5. Sociel Security Number 6. Sex **Funeral** Days Months 1 □ M 21 F 10/28/1909 NEW YORK. 95 Director 072-42-8115 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a, State 10b. County wove r than "natural", or Itame 23a or 28a-f ehov the Medical Examinat must be confided at 1 Yes 2 No Directo ROCKVILLE MARYLAND MONTGOMERY the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 6121 MONTROSE ROAD 20852 Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiana. Int: If item 27 is marked other than "natural", or Ita 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) HOMEMAKER OWN HOME 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be SOLOMON VanDam ANNA LITNER traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 14164 SADDLE RIVER DRIVE, N. POTOMAC, MARYLAND 20878 JUDITH S. SCHNIEBOLK/DAUGHTER permit. Pages 1 and Department of Health Important: If item 27 eny injury or ether troons. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BETH DAVID CEMETERY 03/13/2005 ELMONT, NEW YORK 21. Signature of Funeral Service Licensee 22 Name and Address of Facility
DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.
1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852 DANZANSKY-GOLDBERG MEMORIAL 1170 ROCKVILLE PIKE, ROCKVII

23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HEMI **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Lue to (or as a consequence of): The law requires that the death certificate be executed attending physician and resulting in death) Last Due to (or as a consequence of): Box 68760, Completed by Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Year Day ŏ 4☐Pregnant at time of death 5 Other (specify) Ö the 9 Unknown signed by م 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Vital Records, 3 Probably 4 Unknown 1 Tyes peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed certificate 207 No 1 Yes Physiclan: 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 Yes 2 No 4 Sursing Home 5 Residence 6 Other (Specify) P of this 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Division Hospital or Attending 5 Pending investigation s after death. Il Director: Aft of in by the fur 1 ☐ Yes 2 ☐ No 6 □ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number. City or Town, State) determined filled in by 4 Homicide within 24 hours a 1b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License numbe 29b. Signature and fittle of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ON TROSS 31. Date filed (Month State

Registrar

SHENKMAN

State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Mi	•	Certificate o		i Wentai my	Reg. No					
			Decedent's Name (First, Middle, and American Street)					2. Date of D	eath	2000	3. Time of Death			
	Physicia /Medic			Herbert	STERN			March	7, Da	2005 Year	4:00 A M			
	Examin		4a. Facility Name (If not institution, g	ive street and number)		4b. City, Tow	n, or Location of De			. County of Death				
			Washington Adver	1			ma Park			lont gomer	У			
	Funeral Director		5. Social Security Number  578-46-5630  Usual Residence of Decedent	Sex 7. Ag	69	thday) If Under 1 Ye Months Da			rth ay, Year, 7, 1	9. Birth Cou	place (State or Foreign ntry) York			
	land bw		10a. State 10b. County		10c. City, Town	n or Location					10d. Inside City Limits			
	Mary Ff sh	tor	Maryland Prince	Ceorges	Hazz	attsville					1 ☐ Yes 2 X No			
	or 28g	Director	10e. Street and Number	ocorges.		10f. Zip Cod	le		10g. Ci	itizen of What Cou	ntry?			
	23a c	alD	7304 Riggs Road	#108		2	0783		Uni	ted Stat	es			
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or itams 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☆ Divorced	12. Was Decedent Armed Forces? 1 XYes 2 1 If Yes, Give Year or Dates:	No	13. Was Decedent If Yes, specify C	of Hispanic Origin? Cuban, Mexican, Pue No <i>Specify:</i>	(Specify Yes or N arto Rican, etc.)	0-	14. Race - Ameri Black, White, Specify: Wh	etc.			
- 2	72 ho	eted	15. Decedent's (Specify only highest			Decedent's Usual Oc	cupation	orkina	16b. K	16b. Kind of Business/Industry				
2	vithin ne. han "	Completed	Elementary/Secondary (0-12)	College (1-4or 5		(Give kind of work do life. DO NOT use re	tired)	g						
2	lled w tygier her ti		12 Eather's Name (First Middle 1.2	ctl		Salesman	19 Mother's N	omo (Eirot Middle		me Furni	shings			
auc	ntal hed of	Be								r Surname)				
Ž	should od Me mark matic	은	19a. Informant's Name/Relationship		19b	. Mailing Address (Str			ber, City or Town, State, Zip Code)					
S S	nd 2 stith ar 27 is r trau		Anna Dunn, Niec			40 Santa F								
Baltimore,	ages 1 ar nt of Hear if item or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	☐Removal from State		Disposition (Name of y, crematory or other	1037	Date 11/05		ocation - City or T				
를	artmer ortant injury		*4 ☐ Donation 5 ☐ Other (Spe 21. Signature of Fu teral Service)		George	Washingto		`		lelphi, M	ע			
Ba	Departiment Important			_	-		dress of Facility Ky Hebrew							
			254 Carroll St., NW, Washington, DC  23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final Asystole)											
	Pnysician - /Medical		Immediate Cause (Final disease or condition resulting in death)  Asystole  Due to (or as a consequence of):											
	Examiner													
		ē	Sequentially list conditions, if any, leading to immediate cauce. Enter Underlying		s Melli a consequence									
	d ansit	Examiner	Cause (Disease or injury that initiated events	Hyperte	nsion									
o	rtificate be executed ng physician and as the burial-transit		resulting in death) Last	Due to (or as	a consequence	of):								
68760,	ate be nysici he bu	Aedical		d										
		Med	IF FEMALE:											
.O. Box	res that the death cer igned by the attendin be detached for use	Physician/	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death	3 □Ectopic pregna 5 □ Other (specify				23d. Date of deliv Month	ery Day Year			
J.	s that ned b	by Pt	Part II. Other significant condition:	contributing to death b	ut not resulting in	the underlying cause	given in Part I.	23e. Did	tobacco	use contribute to t	he cause of death?			
rds	w require: been sig should bo						1	. 10	Yes 2	□No 3□Prot	pably 4XDUnknown			
Records,	has has	Completed						24a. Was auto perf 1  Yes	DSV	prior to co	psy findings available mpletion of cause of			
ā		BeC	25. Was case referred to medical				26. Place of D	eath (Check only			20110			
<u>&gt;</u>	d s	ToE	examiner? 1 ☐ Yes 2 🖾 No	Hospital: 1 🔲 Inpatie		tpatient 🕉 DOA	Other: 4 Nursing	Home 5 ☐ Res	idence	6 □Other (Specia	ν)			
n O			27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry 28b. 1 <i>y</i> Ye <i>ar)</i> I		njury at Work?	28d. Describe	how inju	ry occurred				
<u>S</u>	ttendi death. ctor: A y the fu	cat	2 Accident investigat 3 Suicide 6 Could no	bo			1 ☐ Yes 2 ☐ No	201 1						
Division of Vital	or fiter	Certification;	4 Homicide determine	ed 286. Place of Inj building, et	ury - At home, ta c. <i>(Specify)</i>	rm, street, factory, offi	ce	City or To		nd Number or Rura e)	al Houte Number,			
	To the Hospital of within 24 hours a To the Funeral Completely filled in	Medical	29a. Certifier 1 XCertifying (Check only one) 1 Medical Ex	Physician: To the best aminer: On the basis o and manner sta	examination an	, death occurred at the d/or investigation, in m	e time, date and pla ny opinion, death oc	ce, and due to the curred at the time	cause(s date and	) and manner as s d place, and due to	tated. o the cause(s)			
	To th withir To th comp	Me	29b. Signature and file of certifier	100	m	290 Lic	ense number	2/	29d. Da	ite signed (Month,	Day, Year)			
•	10+1		10/	V/L	- / /	DO	10000	(10		ch 7, 200				
	4		30. Name and address of person when Site Ven	5 har pe	eath (Item 23a) (	Type, Print)	lventist	HOSD.	Tai	Kong fa	(+ M)			
	Sta Registr	_	31. Date filed (Month, Day, Year)  MAR 1 1	2005 Registr	ar's Signature	Spelle	1.131		·	-1 /50				
			1111 1	1		/								

		1	_ FOI	artment of Health and Mental Hy	Reg. No. 2 1 0 0 5 0
	Physici	an	1. Decedent's Name (First, Middle, Last) Shelly Lynn Slick	2. Date of D Month	Day Year
>	/Medic Examin		4a. Facility Name (If not institution, give street and number) Washington County Hospital	4b. City, Town, or Location of Death Hagerstown	4c. County of Death Washington
	Funeral Director		5. Social Security Number 218-02-1610 6. Sex 1 M 2 F 37 Yrs.	If Under 1 Year   If Under 24 Hrs.   8. Date of B   Months   Days   Hours   Min.   Min.   Q9/23/	
	yland how		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Lo	ecation	10d. Inside City Limits
	he Ma	ector	MD Washington Hagersto	OWN 10f. Zip Code	1 Yes 2 No 10g. Citizen of What Country?
	3a or 3	I Dir	852 Pine Street	21740	US
36	d within 72 hours after death with the Maryland Jene. r than "natural", or Itama 23a or 28a-f show The Middical Examinat must be indiffied at	by Funeral Director	1 1 N Never Married 2 Married 1 Yes 2 N No	Was Decedent of Hispanic Origin? (Specify Yes or Nif Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 ☐ Yes 2 ☑ No Specify:	o- 14. Race - American Indian, Black, White, etc.  Specify: White
1215-0036	C 2	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	dent's Usual Occupation kind of work done during most of working DO NOT use retired)	16b. Kind of Business/Industry
d 21	Hyg Hyg ant,		12 Ha:	irstylist   18. Mother's Name (First, Middle	Personal Services  p. Maiden Surmame)
/lan	9 6 6 T	To Be	Edward Elwood Slick, Jr.	Nancy Lee Car	r
Maryland	and and sm	e i		ng Address (Street and Number or Rural Route Numb O Spade Road, Hagerstown	
Baltimore,	00-		1 X Burial 2 Cremation 3 Hemoval from State	en Cemetery 03/16/2005	20c. Location - City or Town, State
Baltii	permit. Page Department Important: If any injury of		21. Signature of Funeral Service Lucates e	Minnich Funeral Home gerstown, MD 21740	
8760,	Physician /Medical Examiner	i Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on such line. Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, many, loading to him solate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	Interval Between Onset and Death Onset Ons	
O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medicai		□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
rds, P	w requires that been signed t should be det	by	Part II. Other significant conditions contributing to death but not resulting in the u	11 months and it	tobacco use contribute to the cause of death?  Yes 2 No 3 Probably 4 Unknown
al Records,		Completed		ped 1 Yes	ppsy prior to completion of cause of death? 27No 1 Yes 2 No
Vital	S D	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 No Hospital: ✓ Inpatient 2 ☐ ER/Outpatier	26. Place of Death (Check only ont 3 DOA Other: 4 Nursing Home 5 Res	
n of			27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time o Injury	Work?	how injury occurred
Division	or Attan ifter deatl Director: in by the	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No reet, factory, office 28f. Location City or To	(Street and Number or Rural Route Number, own, State)
	To the Hospital within 24 hours a To the Funaral Completely filled	edical C	29a. Certifiler (Check only one)  Certifying Physician: To the best of my knowledge, deatter (Check only one)  Certifying Physician: To the best of my knowledge, deatter (Check only one)  Certifying Physician: To the best of my knowledge, deatter (Check only one)  and manner stated.		
	To the within To the comp	Me	29b. Signature and title of certifier	29c. License number DH6473	29d. Date signed (Month, Day, Year)  MONCY 13, 2005
5	H-4 Sta Regist	N .	30 Name and address of person who completed cause of death (Item 23a) (Type, 131. Date filed (Monifolds) (Monifold	Print) 1130 OPAL CT.	Hagerstown, MD 44

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2005 Wilmer Α. Sampson Mach /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Year If Under 24 Hrs. Niconico ninsula Legional Nedi al Centa Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min. 1XM 20F Director 215-16-8673 85 Dec.22 1919 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County Show ?7 is marked other then "natural", or iteme 23a or 28a-f shov treumetic event, the Medical Exertities mast be notified at 1 Yes 2 No Director Marvland Wicomico Ouantico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21653 Deep Branch Road 21856 U.S.A Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ≧Yes 2 ☐ No If Yes, Give Year or Dates: WW2 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. int: If item 27 is marked other then "natural", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Completed by 3 Widowed 4 □ Divorced WW2 Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Laborer None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Nellie Cross Wilmer Sampson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Importent: If item 27 Is eny injury or other tret once. 1407 West Rd.Salisbury, Md. 21801 Wilmer L.Sampson (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 KBurial 2 ☐ Cremation 3 ☐ Removal from State Freedman Church Cem.3-12-05 Tyaskin, Md. \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee <sup>22. Name and Address of Facility</sup> Stewart Funeral Home 821 West Rd. Salisbury, Md.21801 Gladys B: Stewar 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician orchan Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to mimediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequen-Examiner transit. The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): burial-t the attending physician Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown à signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ģ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed3 this certificate 2 No 2 1 No 1 Yes 1 Tyes To the Hospital or Attending Physicien: After this certification Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☐Yes 2☐No 2 1☐Inpatient 2☐ER/Outpatient 3☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending within 24 hours after death. To the Funerel Director: A 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 T Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and meaning stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 00053394 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Salisbury Md ANTGON4 J. FREY MD 100 E. Canholl St gistrar's Signature 31. Date filed (Month. Day. 1 4 2005 State Registrar

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			For Amend Item 3 per of Marylands Department of Health and M	•	giene	ibic.	
		•	1 - State Certificate of Death	F	Reg. No	05	LOSEE
	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of Dea Month	Day	Year	8. fime of Death.
	/Medic	al	Richard Franklin Stahl  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	March	11 4c. Count	2005 v of Death	7:00a. M
	Examin	er					o Country
	Funeral		16715 Buford Drive 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)   If Under 1 Year 1 If Under 2 Hrs.   Months   Days   Hours   Min.	8. Date of Birtl (Month, Day	h /, Year)	9. Birthpl Coun	ace (State or Foreign try)
	Director		220–26–5808	Sept 10	1928	Mary	yland
	land ow		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10	0d. Inside City Limits
	e-fsh	ctor	Maryland Washington Williamsport				1 ☐ Yes 2 🔀 No
	or 28	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of	What Coun	try?
	eath v	Funeral	16715 Buford Drive 21795  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spe	city Yes or No-	United 14. Ba	State	
ယ္	after d or Item		Armed Forces? If Yes, specify Cuban, Mexican, Puerto F	Rican, etc.)		ick, White, 6	
21215-0036	d within 72 hours after death with the Maryland jiene. I then "naturel", or Items 23e or 28e-f show ir then "naturel", or Items 23e or 28e-f show ite Modical Exactinet must be notified at	d by	Year or Dates: 1-31-60				
15-(	n 72 h "natu	Completed	15. Decedent's Education (Specify only highest grade completed)  [Give kind of work done during most of workir life. DO NOT use retired]	ng	16b. Kind of E	Business/Inc	dustry
212	within jiene.	ошь	Elementary/Secondary (0-12) College (1-4or 5+)  12 Restaurant		Own	er	
pu	othe	BeC	17. Father's Name (First, Middle, Last)  18. Mother's Name				
yla	should be and Menta marked umetic ev	2	Fred James Stahl Edna Kat				
Maryland	O1 (0 0) (0	¥ (	19a. Informant's Name/Relationship (Type, Print)  Diane Marie Stahl (Daughter)  19b. Mailing Address (Street and Number or Rura 619 Picadilly Drive Ha				
d)	s 1 and 2 f Health item 27 i		20a. Method of Disposition 20b. Place of Disposition (Name of Dispositio	ate	20c. Location		
OE .	Page nent o ant: If iry or		1 Burial 2X Cremation 3 Likemoval from State	14 05	Smiths	ourg M	Maryland
Baltimore,	permit. Pages Department of Importent: If ite eny injury or of once.			_	-		cal Home
_	40 = 0 O		1331 Eastern Blvd. N 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac o			Maryla	
			shock, or heart failure. List only one cause on each line.  Immediate Cause (Final	16			Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)  a	11 4052			
	Examiner		Sequentially list conditions, b				
	ted nsit	Examiner	Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
Ć,	te be executed ysician and ie burial-transit	Exar	that initiated events c. resulting in death) Last Due to (or as a consequence of):				
3760	# % #	icai	d				
x 68	The faw requires that the death certificate bate has been signed by the attending physic age 2 should be detached for use as the bate.	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy		224 D		
Вох	attend attend	cian	23b. Was decedent pregnant in the past 12 months?  1		1	ate of delive onth	Day Year
P.O.	that the de ed by the a detached f	hysi	9 Unknown				
	es thai igned l	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  End Street (100) distributions to death but not resulting in the underlying cause given in Part I.	23e. Did to			e cause of death?
ord	w require been si should I	eted	High Chilesteral Type 2 diebotes Mellites	24a. Was		- 500	
Records,	sicien: The law certificate has b irector, page 2 s	Completed	1-1124 (40125/401, 14/11 2 0/002123 /12/11/165	autop perfo	rmed?	prior to cor death?	psy findings available inpletion of cause of
Vital	76 -	O I	25. Was case referred to medical 26. Place of Death	1 ☐ Yes		1 🗆 Yes	2 □ No
of V	Physicien: this certificated director, particular	To B	examiner?  1   Yes 2   M6   Hospital: 1   Inpatient 2   EP/Outpatient 3   DOA   Other: 4   Nursing Hor				)
o uc		ion:	1. Natural 5 □ Pending (Month, Day Year) Injury Work?	28d. Describe h	now intury occu	rred	
Division	or Attendi after death. Director: A in by the fu	ficat	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office			ber or Rura	l Route Number,
D	tel or A s after el Direc ed in by	Certification:	4 ☐ Homicide determined building, etc. (Specify)	City or Tow	vn, State)		
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Medical (	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.				
	To the within To the comple	Me	29b. Signature and title of certifier  29c. License number  0 -0.054 417		29d. Date sign	ed (Month, I	
)				<i>&gt;</i>	0)11		
05	H-5+1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Sanja Saxena, MD 3 Byrkit Dr., Williamsport, MD 21	795			
Ĭ		ate	31 Date filed (Month, Day, Year) 32, Registrar's Signature	173			
	Regist	rar	MAR 17 2005 Annua D. Sparks				

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. Ng. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month **Physician** 3:36Am brekn Shockle March 0,5 /Medical 4b. City, Town, or Location of Death 4a Fecility Neme (If not institution, give street end number 4c. County of Death Examiner Salisbury eer's Head HOSPITAL Wicomico 8. Date of Birth (Month, Day, Yeer) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6 Sev 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** Days 1 □ M 2 1 1 F Director 217-22-5269 Usuel Residence of Decedent 80 Feb. 9, 1925 Maryland Peges 1 end 2 should be filed within 72 hours efter deeth with the Maryland nent of Health and Mental Hygiene.

Int: If Item 27 is marked other than "natural; or items 23a or 28a-f show ury or other traumatic event, the Medical Examinar must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rai', or items 23a or 28a-f show Examiner must be notified at 1 ☑ Yes 2 ☐ No Director Maryland Wicomico Salisbury 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 351 Deer's Head Hospital Road Funeral 21801 USA 11. Maritel Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Detes: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify þ 3 X Widowed 4 □ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 10th laborer Perdue Farms, Inc. 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) I. Preston Hudson Ellen T. Collins ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Depertment of Health el Important: If Item 27 Is any Injury or other tracence. David Starks/son 3243 Champions Drive, Fairway Falls, Wilmington, DE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Springhill Memory Gdns 03/19/2005 Hebron, Maryland 22. Name and Address of Fecility 1213 Jersey Road - Salisbury, MD 21. Signature of Funeral Service Licens JOLLEY MEMORIAL CHAPEL 21801 23a. Pert1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Congestive heart Immediate Ceuse (Final disease or condition resulting in death) /Medical Examiner Be Completed by Physician/Medical Examiner Oncumonits Attending Physician: The law requires that the death certificate be executed obstructive lung disease Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieled events resulting in death) Last · Chronic Division of Vital Records, P.O. Box 68760, Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No abets meltitus 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? 28/10 11 Was 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Medicai Certification: To 1 Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) To the Hospital or Attending Phy within 24 hours efter deeth.

To the Funeral Director: After this completely filled in by the funeral is 28c. Injury et Work? 27. Menner of Deeth 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 1 Naturel 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 - Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29a. Certifier (Check only one) 29c. License number
D 00 1 600 3 29b. Signature end title of certifier 29d. Date signed (Month, Day, Year) 30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print) BOX 2018, Salisbury, Hwang MID

DHMH 16 Rev 6/95

State Registrar

Ini

31. Date filed (Month Pay

32. Fargistrer's Signature

State of Maryland / Department of Health and Mental Hygiene [] [5] 1- State Registrar AMEND ITEM #1,7,8&17 PER PHYSORIFICAL OF PAGE 1 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death March **Physician** Janice Almon Terry Janice Allmond Terry 2115 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Whitehall 4723 Mellow Rd. 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

O O 71. Yrs Months Days Hours Min. 8. Date of Birth **1930**12/25/1916 Birthplace (State or Foreign New York 5. Social Security Number **Funeral** 1 M 2000 <del>-88</del> 74 214-40-0290 Director Usual Residence of Decedent the Maryland 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Exambramments to profitted at 1 Yes XXNo Director Maryland Harford Whitehall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 4723 Mellow Road 21161 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ∐Yes 2 ŽiNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: þ 3 X Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within: Department of Health and Mental Hygiene. Important: If item 27 is marked other than "r Elementary/Secondary (0-12) 12 College (1-4or 5+) dog breeder dog breeding 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) John Almon Allmond Aggie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4723 Mellow Rd., Whitehall, MD 21161 Elouise Williams (sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ŏ 3/24/05 R.A.Ferris & Comp. West Chester, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Tarring-Cargo Funeral Home, P Aberdeen, Maryland 21001-3399 P.A. irskr H. Unglisber 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Year Day 4□Pregnant at time of death 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? tension 24a. Was an autopsy 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be examiner? 1 Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ 27. Manner of Death 1 XNatural 2 ☐ Accident 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation death. 1 ☐ Yes 2 ☐ No after death 6 Could not be 3 🗍 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funeral ( 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 100 14-206 no completed cause of death (Item 23a) (Type, Print) Name and address of per-HELADIRA AVE 1 31. Date filed (Month, Day, Year) State MAR 2 5 2005 Registrar

			1 - For State Registrar	State of Ma		nd / Depa	artment of I	Health a		ental Hyg	_	05		1358
ı	Physici /Medio		1. Decedent's Name (First, Middle, Last) Milldred			Thoma				2. Date of Dea March	6, 200		3. Time of 5:03	of Death
- 4	Examir Funeral	ier	4a. Facility Name (If not institution, give a Calvert Memoria  5. Social Security Number 6. September 6. Sept	1 Hospit		last birthday)	4b. City, Town, or Prince	Fred	deri	C.k.  B. Date of Birth A. (Month, Day A.U.g., 17		1ve	rt place (State	or Foreign
	Director		218−34−6640 1□ Usual Residence of Decedent 10a. State 10b. County	] M 2□XF	7 4	Yrs. ty, Town or Lo	Months Days	Hours	Min.	Awg 17	7,7930	Mar	ylan o	1
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-f ahow any injury or other traumatic avent, the Medical Examinate multiple all once.	Funeral Director	Maryland Calv  10e. Street and Number  4710 Solomons		oad		untingt			1	log. Citizen of W USA			s 2 🔀 No
36	urs after deatt of, or items 2 zaminer mul	by	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:		1	Was Decedent of I f Yes, specify Cub 1 ☐ Yes 2 ☐ No		gin? (Spec , Puerto R	ify Yes or No- ican, etc.)		- Americ c, White,		
Maryland 21215-0036	I within 72 houlene. The Medical Eller Medical Eller	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e com <i>pleted)</i> College (1-4or 5-	-)	16a. Deced (Give life.	dent's Usual Occu kind of work done DO NOT use retire Cook	pation during most id)	t of working	g	16b. Kind of Bu		•	
yland	ould be filed Mental Hyg wrked othe	To Be C	17. Father's Name (First, Middle, Last) Henry		Lo			Mary	y		Maiden Surnam	Cha	ase	
	s 1 and 2 sh f Health and item 27 le rr other traurr		19a. Informant's Name/Relationship (Ty Mabel Jones/Dau 20a. Method of Disposition	ghter	20b. F	JUZJ	Solom of partners of the state	115 13	51411	T KG.H	City or Town, BO Untine 20c. Location	town	n.MD2	10639
Baltimore,	permit. Pages Department of Important: If it any injury or once.		1  Burial 2  Cremation 3  ☐ R  '4  ☐ Donation 5  ☐ Other (Specify)  21. Signature of Funeral Service License		Pa		t UMC c				Huntin uneral	_		
760,	ate be executed  Wedical  Whysician and  Proposed the printing of the printing	icai Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that inditated events resulting in death) Last	a. Pula to (or as a	conseq	juence of):	er the mode of dy	ng, such as o	cardiac or	respiratory arr	est,		Approxima Interval Be Onset and	etween
O. Box 68	that the death certificat, led by the attending phy detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t	Feta	I death 3	Ectopic pregnanc	у		·····	23d. Date Mon		,	Year
ords, P.	The law requires that the ste has been signed by th page 2 should be detache		Part II. Other significant conditions con	ntributing to death bu	t not res	ulting in the u	nderlying cause gr	ven in Part I.			pacco use contri			deat1? Unknown
al Kecords,		Completed								24a. Was a autops perform	ned? of	ere autorior to consath?	osy findings npletion of c	available cause of
of Vital	Physician: this certific ral director,	To Be	1 195 2 100	lospital:		ER/Outpatien	1 3 DOX	ner: 4 🗌 Nur	rsing Hom		ence 6 Othe		•)	
Division	uttending death. ctor: After y the fune	Certification:	27. Mann of Death  1 v atural 2 Accident 3 Suicide 4 Homiside 5 Pending Investigation 6 Could not be	28a. Date of Injury (Month, Day) 28e. Place of Injury	Year)	28b. Time of Injury ome, farm, str		ryat rk? ]Yes 2 □ N	No		ow injury occurre		I Route Nun	n ber.
á	To the Hospital or Attanding within 24 hours after death.  To the Funeral Director: After completely filled in by the fune		4   Normiciae	building, etc.	(Specif	y) wledge, death	occurred at the ti	me, date and	d place, an	City or Town	n, <i>Ștate)</i>	iner as sta	ated.	
	To the h within 24 To the F complete	Medical	one) 29b. Signature and title of certifier	and manner stat	ed.		29c. Licens		C/		9d. Date signed			5)
	a		30. Name and address of person who co	impleted cause of de	ath (Iten	n 23a) (Type,	Print)	1168	5		5/7/	05		
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	's Signa	2.0.13 ature	0x 70	Hur	Him	g tou	n M	00	063	7
-	Registr	ar	MAR 1 0 2005	Roman	4	AND MA								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year Peggy nasch Taylor 4c. County of Death /Medical Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Vicomica egional Medical ( 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) 12/8/1927 Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🖫 F 213-22-8593 Director Maryland n Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 213 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the Mudical Examiner must be notified at once. Maryland Wicomico Funeral Director Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4647 Southwood Terrace 21804 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: þ white Specify: 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Office Manager 12 Preston Trucking Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Fred Webster Addie Dunn ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia A. Taylor/daughter 4647 Southwood Terrace, Salisbury, MD 21804 20b. Place of Disposition (Name of cometery, crematory or other place)
Springhill Memory
Gardens 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 3/17/05 <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) Hebron, MD 22. Name and Address of Facility
Holloway Funeral Home Professional Association
501 Snow Hill Rd., Salisbury, Maryland 21804 21. Signature of Funeral Service Licente 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Physician **Physici** /Medical Examiner Physician/Medical Examiner þ Completed

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760. After I Director: / within 24 hours a To the Funeral D

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	Immediate Cause (Final disease or condition resulting in death)	a Consestive	teant to	i. lune	Onset and Death
Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):  C. Due to (or as a consequence of):	pothy		
edi					
hysician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		ic pregnancy r (specify)		23d. Date of delivery Month Day Year
ted by PI	Part II. Other significant conditions	contributing to death but not resulting in the underlying	ng cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
	Dighast	٤		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
Be	25. Was case referred to medical examiner?	Hereitele a		th (Check only one)	
P	1 ☐ Yes 21 No	Hospital: 1 patient 2 ER/Outpatient 3	DOA Other: 4 Nursing He	ome 5 Residence	6 ☐Other (Specify)
atlon:	27. Manner of Death  1 Statural 5 ☐ Pending 2 Accident investigation		28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju	ary occurred
Certific	3 Suicide 6 Could not to determined		ctory, office	28f. Location (Street a. City or Town, State	nd Number or Rural Route Number, e)
Medical Certification:	29a. Certifier (Check only one) Certifying Plant 2 Medical Exa	hysician: To the best of my knowledge, death occur iminer: On the basis of examination and/or investig <i>a</i> and manner stated.	rred at the time, date and place, ttion, in my opinion, death occur	and due to the cause(s red at the time, date an	s) and manner as stated. d place, and due to the cause(s)
Σ	29b. Signature and title of certifier	n. C. Duland Min	29c. License number 34768	29d. Da	te signed (Month, Day, Year)
	18 Play	continuous cause of death (Item 23a) (Type, Print) Willard my 100 E. CAN	null St. Sal.	Shung M	d
te	31. Date filed (Month, Pay Year)	2005 32. Figistrar's Signature	. 0		

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1 ☐ Yes 2 ₩ No

Registrar

			For Stete	State of M	larylar	-	artment of			-	0	1 1 m	100	
			Registrar  1. Decedent's Name (First, Middle,	Last)		Cei	uncate of	Dealli		2. Date of De	Reg. No.	000	3. Time	of Death
v	Physici /Medio		Robert Louis Van	Boven					M	Month Iarch 1	11, 20	005 Year	5:10	а м
	Examir		4a. Facility Name (If not institution,	give street and number	)		4b. City, Town,		of Death			County of Dea	th	
			2 Prospect Ave. 5. Social Security Number	6. Sex 7. A	no /In vre	last birthday)	Indian If Under 1 Yea		24 Hrs o	Data of Bir		narles	th along (State	
	Funeral Director		349-20-7890	1 XM 2□F	76	Yrs.	Months Day:		Min. S	B. Date of Bir (Month, Pa ept • 4	<sup>19</sup> 1928		thplace (State ountry) LNOIS	or Foreign
	pu ,		Usual Residence of Decedent		140- 00									
	f shov	ō	10a. State 10b. County  Marvland Charl	00		y, Town or Lo							10d. Inside 0	City Limits s 2 □ No
	28a-	Directo	Maryland Charl  10e. Street and Number		1110	dian He	10f. Zip Code				10a. Citi	zen of What C		
	th with	a D	2 Prospect Ave.				2064	0				J.S.A.		
	tems	Funeral	11. Marital Status	12. Was Decedent Armed Forces	?	.S. 13.\	Was Decedent of f Yes, specify Cu	Hispanic Ori ban, Mexicar	igin? (Speci n, Puerto Ri	fy Yes or No	)-	14. Race - Am Black, Whi		
36	irs afte	by F	1 ☐ Never Married 2 ☐ Marrie 3 🖫 Widowed 4 ☐ Divorced	od 1 ∑Yes 2 ☐ If Yes, Give Year or Dates:	No		1 ☐ Yes 2🎇 No				1	Specify: Wh:		
9	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or flems 23e or 28e-f show ont, the Madical Examir ser must be notified at	ted	15. Decedent's	s Education		16a. Deced	lent's Usual Occi	pation				nd of Business		
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d 2	filed w Hygie ther t	Co	10 17. Father's Name (First, Middle, L	ast)		Rallic	oad Dispa			First, Middle,		Govern	nment	
ltimore, Maryland 21215-0036	bed a la la la la la la la la la la la la l	To Be	Peter VanBoven	*				1.4		Waas	17/2/30/1	ourname,		
lary	is 1 and 2 should of Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationshi	_		T.	g Address (Stree						Zip Code)	
e,	1 and 1ealth sm 27 ther tr		Donna Owen  20a. Method of Disposition	Daughter	20h E	4614	Rincon I	Place,	Dumf:	ries,			T	
nor			1 X Burial 2 ☐ Cremation 3		Tro	emetery, cren	sition (Name of natory or other pl	Garde	h 15,	2005		cation - City or		
Baltir	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Li		**-		Name and Addi Villiams					OLL, M	тутано	
<u>~</u>			poly	W .	M0066	4	270 Haw	thorne	Rd.,	India	n He	ad, Md.	20640	
			23a. Part1. Enter the disease, or of shock, or heart failure. List o	niy one cause on each i	ine.		er the mode of dy	ing, such as	cardiac or r	espiratory ar	rre <i>s</i> t,		Approxima Interval Be Onset and	tween
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. MUL			MYE	iom 4					Offiset and	Dealii
H	Examiner			Due to (or as	a conseq	uence of);								
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Uncertying	b. Due to (or as	a conseq	uence of):								
	and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	0.000000	uanao of):								
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9	titicate ng phy as the	ledic		σ.										
Вох	leath certitic attending p	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth			Ectopic pregnanc	ey			2	3d. Date of de	,	V
	0 0 0	hysician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□ Unknown	t time of d	eath 5□	Other (specify)					Month	Day	Year
J.	that the	by Ph	Part II. Other significant condition	s contributing to death I	out not res	ulting in the un	iderlying cause g	iven in Part I.		23e. Did to	obacco us	se contribute to	the cause of	death?
rds,	w requires been sign should be									1 🗆 Y	/es 2[	□No 3□Pr	obably 4	Inknown
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<u>m</u>		Con								perfor		death? 1 ☐ Yes		
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סו	ding Phys h. After this funeral di	$\vdash$	27. Manner of Death	1 ☐ Inpation 1 ☐	ıry	ER/Outpatient 28b. Time of Injury	28c. Inju	4 🗆 INU		d. Describe h		Other (Spe	cify)	
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Division	P S S S S S S S S S S S S S S S S S S S	ertification;	3 Suicide 6 Could no 4 Homicide determin				et, factory, office		28f	Location (S City or Tow		Number or Ru	<i>iral Route</i> Num	iber,
_	spital or hours after nerel Dir filled in	O	29a. Certifier 1 Certifying	Physicien: To the best	of my kno	wledge, death	occurred at the t	ime, date an	d place, and	d due to the o	cause(s)	and manner as	stated.	<u> </u>
	To the Hos within 24 h To the Fun completely	edical	(Check only 2 Medicel Ex											5)
	o T with	2	29b. Signature and little of gertifier	M			29c. Licen	se number	8	1	29d. Date	signed (Monta	h, Day, Year)	
			3Q. Name and address of person N	To completed cause of	death (Item	2 <b>27</b> ) (Type: F	29c. Licen D Print) Office	2 20	د ن			1120	<b>~</b> >	
Di	3HE1		VENKAT- S. K	Amhran	50	1051	OFFICE	KOM	4 30	04 WA	1000	f MD	2060	2
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			1 - For State Registrar	State of M	aryland / [	Departm <i>Certific</i>			nd Mental H	ygiene Reg. No.20	05	10362
I	Physici /Medio		1. Decedent's Name (First, Middle, It  KAREN FAYE	ast) VanMETE	3				2. Date of D Month	Day OS	Year	3. Time of Death
	Examir		4a. Facility Name (If not institution, g  Social Security Number 6.	+ Hospi	taL e (In yrs. last bir	C	city, Town, or	Location of E	ind	1 3	egan	
	Funeral Director		216-66-2479 Usual Residence of Decedent	1□ M 2XF		Yrs. Mont			Min. (Month, C	25,1954		lace (State or Foreign try) YLAND
	se Marylan Ba-f show	ctor	MD ALLE	GANY	10c. City, Tow	n or Location	)				11	0d. Inside City Limits 11∏Yes 2 □ No
21215-0036	permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. If a Meulical Externing the restituted and once.	eted by Funeral Director	100 MULLEN STRE.  11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed ▼ □ Divorced  15. Decedent's (Specify only highest of	12. Was Decedent Armed Forces?  1  Yes  Yes  If Yes, Give Year or Dates:	No	13. Was De If Yes, 1	s 2 No  Jsual Occupa	n, Mexican, P	1? (Specify Yes or Note to the state of the		A . e - Americ ck, White, e	an Indian, etc. TE
	e filad within al Hygiene. I other than " vent, ILE Me.	Completed	Elementary/Secondary (0-12)	College (1-4or 5		life. DO NO	T use retired,	ING AS	SSISTANT	NURSI		
Maryland	should be fill nd Mental Hy marked oth umatic even	To Be	17. Father's Name (First, Middle, La. CHARLES T. PLUM	ŒR				VIOI	Name (First, Middle LET L. GAI	RLITZ		
	1 and 2 sho Health and em 27 is m		19a. Informant's Name/Relationship CHARLES VanMETE			106 MU	LLEN S		CUMBERLA	AND, MD	2150	2
Baltimore,	Pages 1 ment of H tant: If iter jury or oth		20a. Method of Disposition  1   Burial 2 □ Cremation 3  4 □ Donation 5 □ Other (Special Control of the Control		cemeter		or other place IAL PA	RK 03	Date 8/14/2005		-	wn, State
Bail	permit. Pag Department Important: any injury o		21. Signature of Funeral Service Lin	lepcherc	'/	22. Name UPC 202	and Addres HURCH GREEN	s of Facility FUNERA E STRE	L HOME, P	P.A. ERLAND, M	1D 2	1502
	Physician / Medical Examiner	Examiner	23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as b. Due to	a consequence	rest of): Tran			ortic A			Approximate Interval Between Onset and Death
.O. Box 68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	d	2 Fetal death	3 □Ectopi 5 □ Other	c pregnancy (specify)			23d. Dat	e of deliver	ry Day Year
rds, P	quires that in signed t uld be deti	þ	Part II. Dither significant conditions HISTORY OF	contributing to death b	ut not resulting in Aocti	- 0	ig cause give			tobacco use contr Yes 2 □ No	nbute to the	
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Division of Vita	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Diractor: After this certificate ha completely filled in by the funeral director, page	To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manne of Death 1 Natural 5 Pending investigat	Hospital: 1 Inpatie 28a. Date of Inju (Month, Da	ry 28b. 1	Itpatient 3 Time of njury	DOA Othe	r: 4 □ Nursii	Death (Check only ng Home 5 🗆 Res 28d. Describe			)
Divisi	al or Attendi after death. I Diractor: A d in by the fu	Certification:	3 Suicide 6 Could not determine	be 300 Place of Ini		ırm, street, fac	story, office			(Street and Number own, State)	er or Rural	Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Dirac completely filled in by	Medical C	29a. Certifier (Check only one)  1 Certifying 1 2 Medicel Ex	Physicien: To the best eminer: On the basis of and manner sta	examination an	e, death occur d/or investigat	red at the timition, in my op	e, date and p inion, death o	place, and due to the occurred at the time	cause(s) and ma , date and place, a	nner as sta and due to	ited. the cause(s)
}	To the I	Ň	29b. Signature and title of gartyler			-	29c. License	number 5635	5	29d. Date signed		ay, Year)
	THS		30. Name and address of person wh	completed cause of d	eath (Item 23a) (	(Type, Print)	æ, C	imb	erland			52
	Sta Registr		31. Date filed (Month, Day, Year) MAR 1 5 2	32 legistr	ar's Signature	Societ.	,					

Virgil Workman 05-1928 AKG

Please Type or Printin Plack Ink. Ensure All Copies Are Legible.
unpend item#23a, 27, permit, to 4 Place Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Maryland	-	tificate of		ı Mentai my	Reg. No.		
			1. Decedent's Name (First, Middle, La	st)				2. Date of D	eath	005	3. Time of Death
	Physic		Vir	gil Workman				March	17. 200	Year 15	9:39 A
	/Medi Examir		4a. Fecility Name (If not institution, giv			4b. City, Town, o	r Location of De			nty of Death	9.39 A
1	ZX		961 Ebenezer Chu	rch Road		Rising	Sun		Cec	vi 1	
9	Funeral		5. Social Security Number 6. S		ast birthday)	If Under 1 Year	If Under 24 H				lace (State or Foreign
2	Director		216-76-2403 Usual Residence of Decedent	X <sup>M 2□ F</sup> 44	Yrs.	Months Days	Hours M	DEC 24	4, 1960	Cour	Virginia
,	yland Now		10a. State 10b. County	10c. City	, Town or Loc	ation				1	0d. Inside City Limits
	a-fsh	ţċ	Maryland Cecil	Ri	sing S	un					1 ☐ Yes 2 📉 No
	th the	lre	10e. Street and Number			10f. Zip Code			10g. Citizen	of What Cour	ntry?
	23a	la	961 Ebenezer Ch	ırch Road		21911			Unit	ed Sta	ates
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "netural", or Items 23s or 28s-f show any injury or other traumatic event, the Madical Expendituation indiffed at 2006.	by Funeral Directo	11. Marital Status  1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1	as Decedent of H Yes, specify Cuba		(Specify Yes or Nerto Rican, etc.)	0- 14. F B Spe	lace - Americ lack, White, cify: Whi	etc.
5	72 he 'netu	etec	15. Decedent's Education (Specify only highest gra		16a. Decede	ent's Usual Occup	ation during most of v	vorkina	16b. Kind of	Business/Ind	dustry
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Maryland	ild be lental ked i	To B	Jim Workman				Nina	Williams	on		
37	Shound M	-	19a. Informant's Name/Relationship (	Type, Print)	19b. Mailing	Address (Street a	and Number or	Rural Route Numb	per, City or Tox	m. State, Zip	Code)
	nd 2 alth a 27 ls		Shirley Everett	/Companion				Road, Ris			
Baltimore,	Pages 1 and the period of the		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □	memoval ilom State	ace of Disposi emetery, cremi	ition (Name of atory or other plac	e) Ma:	rch 22,	20c. Locatio	n - City or To	wn, State
altin	permit. Pa Department Importent any injury		<ul> <li>4 ☐ Donation 5 ☐ Other (Specify</li> <li>21. Signature of Funeral Service Licer</li> </ul>			emetery Name and Addres	20 ss of Facility		E1kto	n, Mar	yland
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Division	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		me, farm, stree )		20,10	28f. Location ( City or To		nber or Rural	Route Number,
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)	To the within To the comp	Me	29b. Signature and title of certifier  Za Liu.u	elah Ali		29c. License OCME	number		29d. Date sign March		
			30. Name and address of person who ZABILLC	AH AU	L		nn Stre	et Balt	imore,	Maryla	nd 21201
	Sta Registr	5	31. Date filed (Month, Day, Year) MAR 2 5 26	32 Registrar's Signatu	Los Los	de					

		1	State of Maryland / Dep  State of Maryland / Dep  Registrar  Ce	artment of Health and I rtificate of Death		ene .No. 2005	in .
			Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time bi Death
	Physicia /Medic	_	Samuel Kaye Watson		March 3	, 2005	4:40 P. M
į.	Examin		4a. Facility Name (If not institution, give street and number) 14107 Oakvale Street	4b. City, Town, or Location of Death  Rockville	h	4c. County of Death  Montgo	me rv
5			5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	T W.H	8 Date of Birth	•	place (State or Foreign
	Funeral Director		225-54-4276 1X M 2 F 61 Yrs.	Months Days Hours Min.	(Month, Day, Y) February	25. Vi	ntry) rginia
			Usual Residence of Decedent				
	how		10a. State 10b. County 10c. City, Town or L			1	10d. Inside City Limits 1 1 Yes 2 □ No
	Ba-f e	Director		ville	100	, Citizen of What Cou	
	with the		10e. Street and Number  14107 Oakvale Street	10f. Zip Code 20853		nited State	
	d within 72 hours after death with the Maryland Jiene. I than "natural", or Items 23a or 28a-f ehow The Medical Examinating must be notified at	Funeral	11 May Decedent Ever in U.S. 13	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl		14. Race - Americ	can Indian,
_	r iten	표	1 Never Married 2 Married 1 X Yes 2 No 1 0 55_	If Yes, specify Cuban, Mexican, Puerl  1 ☐ Yes 2X No Specify:	to Rican, etc.)	Black, White,	etc. Lack
2-003p	hours after tural", or ite al Ezatraba	þ	3 ☐ Widowed 4 NDivorced Year or Dates April 1967				
ק	72 h	ete	15. Decedent's Education (Specify only highest grade completed) (Given the complete of the com	edent's Usual Occupation  s kind of work done during most of wor  DO NOT use retired)	rking 16	b. Kind of Business/In	
7	within ene. than	Completed	Flementary/Secondary (0-12) College (1-40r 5+)	Printer		xchange Co	mmission
מ	Hyg at the		17. Father's Name (First, Middle, Last)	18. Mother's Na	m <i>e (First, Middle, Ma</i>	iden Sumame)	
<u>a</u>	o ta o	To Be	Edward Watson	Betty	Martha	Booker	
a <sub>Z</sub>	should and Men s marks sumatic			ing Address (Street and Number or Ru	ural Route Number, C	City or Town, State, Zip	Code)
, Ma	and 2 ealth a n 27 is			Continental Plac			
Baltimore,			1 Burial 2 Cremation 3 Hemoval from State			c. Location - City or T	
	permit. Pag Department Important: eny injury o			ike Crematory, Inc		eltsville,	
Ra	permit. Pag Department Important: I eny injury o once.		Sandelph D. Horton	2 Name and Address of Facility R. N. Horton Comp 600 Kennedy Stree	t,N.W.;Was	shington,D	.c. 20011
H			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardia	c or respiratory arres	t,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition a. My o CAKAL	of INFA	den		5 mounts
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):	11 7 1	den 115095e		10.1300
		-	Sequentially list conditions, fragulated by Due to (or as a consequence of):	entic Henry U	isease		109245
	nted insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
Ć.	exect an and rial-tra		that initiated events resulting in death) Last				
8760	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	dical	d				
9	artifica ing ph e as t	Med	IF FEMALE:				
Вох	w requires that the death certific been signed by the attending p should be detached for use as i	Physician/Me	23b. Was decedent pregnant  1 Live birth 2 Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)		23d. Date of deliv Month	Day Year
P.O.	he de	ysic	1 Yes 2 No 9 Unknown				
۳.	that the sed by detail		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
rds	quires on sign	ed by	Hypertension		1 ☐ Yes	2 <b>3</b> Pro	bably 4 Unknown
000	aw rec s bee 2 sho	plet			24a. Was an autopsy		opsy findings available ompletion of cause of
ž	The lavate has	Completed			performe	ed? death? DNo 1 ☐ Yes	
ita	ilcian: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?		ath (Check only one)	)	
5	Physic this or al dire	2	1 X Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpati		Home 5 Residen 28d. Describe how	ce 6 Other (Speci	(b)
n C	Jing F	lon	1 Natural 5 Pending (Month, Day Year) Injury	of 28c. Injury at Work?  M 1 □ Yes 2 □ No	200. Describe now	injury occurred	
Division of Vital Records,	or Attending Physician: after death. Director: After this certifici in by the funeral director,	fical	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm,			et and Number or Rur	al Route Number,
<u>S</u>	al or / after i Dire d in b	Certification:	4 Homicide determined building, etc. (Specify)		City or Town,	State)	
	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical (	29a. Certifier  1 Certifying Physician: To the best of my knowledge, de.  (Check only one)  1 Medicel Examiner: On the basis of examination and/or and manner stated.	ith occurred at the time, date and place nvestigation, in my opinion, death occurred.	e, and due to the cau curred at the time, dat	use(s) and manner as se and place, and due	stated. to the cause(s)
	within 2 To the Complet	Me	29b. Signature and title of certifier	29c. License number	290	d. Date signed (Month,	. Day, Year)
			Dean Wew Stree M	1000 9748	MA	March 7	, 2005
R	(5)		30. Name and address of person who completed cause of death (Item 23a) (Typ	e. Print)			20902
			Alan R. Weinstock, M.D.; 10313 Geor	gia Avenue;Suite	105;Silver	Spring, N	faryland
	St Regist	ate rar	31. Date filed (Month, Day, Year)  MAR 1 1 2005	with the same of t			

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of M	-	artment of F		nd Mental Hy	giene Reg. No. 2	005	10000
			Decedent's Name (First, Middle, Last	)				2. Date of De	ath	UUJ.	3. Time of Death
	Physici		Velia Ratliff Wear	<i>r</i> er				Month March	10	Year 2005	1:45 A M
	/Medio Examir		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of			unty of Death	117J A
			979 Bouchelle Road	i		E1kton			Ce	ci1	
	Funeral		Social Security Number     6. Se		e (In yrs. last birthday	If Under 1 Year Months Days	If Under 24	Hrs. 8. Date of Birl Min. (Month, Da	th v Year)	9. Birthp	ace (State or Foreign
	Director		229 01 /422	]м <b>Ж</b> ]F	87 Yrs.	IVIOTITIS Days	FIODIS		1917	Virgi	
	pug *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation				11	Od. Inside City Limits
	sho	5				Soution				"	1 ☐ Yes 2 No
	the N	Director	Maryland Cecil  10e. Street and Number		E1kton	10f. Zip Code			10- 0:1	of What Coun	
	with of the	ā		_							,
	eeth	era	979 Bouchelle Road	12. Was Decedent	Ever in U.S. 13	Was Decedent of H	lienanie Origi	n? (Specify Yes or No		d State Race - Americ	
40	Iten Iner	Funerai	1 ☐ Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🔯		If Yes, specify Cuba	an, Mexican,	Puerto Rican, etc.)		Black, White,	
036	urs a	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🗓 No	Specify:		Sp	ecify: Whi	te
21215-0036	within 72 hours after deeth with the Maryland ene. then "natural", or Items 23a or 28a-f show fra Medical Examinar mual be notified at	Completed	15. Decedent's Edu	cation		edent's Usual Occup		, ,,	16b. Kind	of Business/Ind	lustry
215	Med	pie	(Specify only highest grad	College (1-4or 5	life.	e kind of work done DO NOT use retired	auring most a d)	nt working			
21	filed with! Hygiene. ther then	Соп	7			maker			Own ]	Home	
nd	al Hygie d other	Be (	17. Father's Name (First, Middle, Last)				18. Mother's	s Name (First, Middle,	Maiden Sui	mame)	
Via	Mental Merkad o	To I	James T. Ratliff				Ora B	elle Stilt	ner		
Maryland	2 should be and Mental Is marked ( sumatic ev		19a. Informant's Name/Relationship (T)	грө, Print)	19b. Mail	ing Address (Street	and Number	or Rural Route Numbe	er, City or To	wn, State, Zip	Code)
≥,	s 1 end 2 should be filed within 72 hours after deeth with the Marylan Fheath and Mental Hygiene. Fheath and Mental Hygiene filem 27 Is marked other than "netural", or Items 23a or 28a-1 show item 27 Is marked other than "netural" or rollified at other traumatic event. Its Medical Examinar must be notified at		Reginald Weaver/Hu	ısband			Road,	Elkton,Mar			
Baltimore,	permit. Pages 1 end 2 Deportment of Health s Important: If item 27 li eny Injury or other tra		20a. Method of Disposition  1X Burial 2 □ Cremation 3 □ F	Removal from State	20b. Place of Disp cemetery, cre	osition (Name of omatory or other plac	<sup>(в)</sup> Ма	rch 12,	20c. Locati	on - City or To	wn, State
Ë	Pag ment ant: jury c		'4 □ Donation 5 □ Other (Specify)			Cemetery	į	2005	Bay V:	Lew Mar	vland_
Sali	Departition Depart		21. Signatura 15 meral Service Life is					Crouch Fu	neral	Home	
_	<u></u>		poly a					treet,Nort		Mary1,	and 21901
			23a. Part1. Enter the disease or compl shock, or heart failure. List only or	ications that caused ne cause on each li	I the death. Do not er ne.	iter the mode of dyin	g, such as ca	urdiac or respiratory ar	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	CHRON	IC DBSTA	UCTIVE P	4 LM ONC	ory Diseas	R - END	STABLE	Onset and Death
П	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):			)			
		<u>.</u>	Sequentially list conditions,	Due to /or as	a consequence of):						
0	ted nsit	nin	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 10 (01 23	a consequence or,						
	al-tra	Examiner		Due to (or as	a consequence of):						
8760,	icate be executed physicien and s the burial-transit	dicail	L.	4							
9	tificat g phy as th	<b>9</b> 1									
Вох	eath certifi attending     for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome					23d.	Date of deliver	у
	deati e atte	icia	in the past 12 months? 1 ☐ Yes 2 🙀 No	4 ☐ Pregnant at		□Ectopic pregnancy □ Other (s <i>pecify</i> )				Month I	Day Year
P.0	at the de by the stached	hys	9 Unknown	9□ Unknown							
	The law requires that the death certific te has been signed by the attending p age 2 should be detached for use as	by F	Part II. Other significant conditions con	ntributing to death b	ut not resulting in the t	underlying cause give	en in Part I.	23e. Did to	bacco use o		e cause of death?
Vitai Records,	w requir been si should	ted	DIABETES					1	′es 2□N	o 3 Proba	abiy 4 🗆 Unknown
ecc	law r as be 2 sh	Completed						24a. Was autop		tb. Were autop	sy findings available
		Con						perfor 1 ☐ Yes	rmed2 22 No	death?	
'ita	ilcian: Th certificete rector, pag	Be (	25. Was case referred to medical examiner?				26. Place of	f Death (Check only o	-		
<u></u>	d is	70	1 ☐ Yes 2 No	lospital: 1 🔲 Inpatie	ent 2 ER/Outpatie	nt 3 DOA	er: 4 🗆 Nursi	ing Home 5 Resid	lence 6 🗆	Other (Specify)	
ם	iding Ph th. : After th funeral	on:	27. Manner of Death  1 X Natural 5 □ Pending	2Ba. Date of Inju (Month, Da	ry 2Bb. Time o	of 28c. Injun Worl	at </td <td>28d. Describe h</td> <td>low injury oc</td> <td>curred</td> <td></td>	28d. Describe h	low injury oc	curred	
sio	Attending it death. ector: After by the funer	cati	2 Accident investigation 3 □ Suicide 6 □ Could not be			M 1	Yes 2□No				
Division of	or At after d Direct in by	Certification:	4 Homicide determined	28e. Place of Injuding, etc	ury - At home, farm, st c. <i>(Specify)</i>	reet, factory, office		28f. Location (S City or Tow	Street and Nu n, State)	amber or Rural	Route Number,
	pitel urs a sral C			<u>                                      </u>				N. T.			
	To the Hospitel or Attend within 24 hours after death To the Funeral Director: completely filled in by the f	Medicai	29a. Certifier 1 Certifying Physical Check only one)	ner: On the basis of and manner sta	examination and/or in	th occurred at the time the time time time the time of time of the time of tim	ne, date and p pinion, death	place, and due to the o occurred at the time, o	ause(s) and date and pla	manner as sta ce, and due to	ited. the cause(s)
	ithin o the	Mec	29b. Signature and title of certifier	and manner sta	ited.	29c. License	number		29d. Date sid	ned (Month, D	Pav. Year)
	- s - ŏ		16. F x5	MAT	\				3	+/200	_
	10		30. Name and address of person who co	mpleted cause of d	eath (Item 23c) (Turn	Print) 223	141 MA	71	וונכ	7/200	
	9			BLOWN	eau (116111 238) (1906,	(C) x	700	49 AIN 5TREE MD 21	1921	1	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature		1101	1000	101		
	Registr	_	MAR 1 4 2005	Jan Min	A STATE	refer					

			1 - For Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment of F			iene 00	5 10366
*1	*	3	Decedent's Name (First, Middle, Last	)				2. Date of Dea		3. Time of Death
	Physic		Mary Agr	es Wil	lliams			March 1	1, 2005 Ye	
	/Medi Examir		4a. Facility Name (If not institution, give			4b. City, Town, o	or Location of Dea		4c. County of E	
	LAGIIII		Bayside Care Cer	iter		lexing	ton Park		St. Ma	
	Funeral		5. Social Security Number 6. Se	x 7. Age	(In yrs. last birthday,	If Under 1 Year	If Under 24 Hrs		9	Birthplace (State or Foreign
	Director		216-40-9455	⊒M 2(X) F ]	LO7 Yrs.	Months Days	Hours Min	May 4.		Maryland
	p		Usual Residence of Decedent  10a, State 10b, County		10c. City, Town or L					
	sho	7	,		Toc. City, Town or E	ocation				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	Ne M	ecto	MD St. Mar	y's	Charlot	te Hall				
	with t	吉		1 D 1		10f. Zip Code		1	0g. Citizen of What	t Country?
	eath	Funeral Director	29828 Three Knot	CN KOAQ 12. Was Decedent Ev	tor in 11 S 12	20622	liannoia Osiaia 2 (1	3	U.S.A.	N-7
	ter d Itam	Ë	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?		Was Decedent of H If Yes, specify Cub	an, Mexican, Pue	to Rican, etc.)		American Indian, Vhite, etc.
336	urs af	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	·	1 ☐ Yes 2 🛣 No	Specify:		Specify:	White
215-0036	within 72 hours after death with the Maryland ene. than "natural", or Itama 23e or 28e-f show fe Mazileal Ever in et most bu credified at	Completed	15. Decedent's Edu		16a. Dece	dent's Usual Docup	ation		16b. Kind of Busine	
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21	giene giene greth	Son	12			memaker			Own Hom	ie
pu	be filed ital Hygird of other avent, I	Be (	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle, I	Maiden Sumame)	
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	ss 1 and 2 should be filed within 72 hours after death with the Marylar of Heatih and Mental Hygiene. itam 27 ia marked othar than "natural", or Itama 23a or 28a-f show othar traumatic avent, I're Medical Eva chies inner by restilled at	1 2	Mary Lillian Maed	ge – daugh	ter 1136	2 Lower M	larine Ro	ad. High	land, IL	62249
Baltimore,	of H of H if itan	ll i	20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation 3 ☐ F		20b. Place of Dispo	osition (Name of matory or other plac		Date	20c. Location - City	or Town, State
Ē	Pages ment of I ant: If its ury or o		'4 Donation 5 □ Other (Specify)	iomoval from Glato	St. Mary'	s Church	Cem. 03-	-14-2005	Bryantow	n, MD
ăali	permit. Pages Department of Important: If i any injury or o		21. Signatur - Fund al Sevice Licens	ee M01391	2:	2. Name and Addre Huntt Fu	ss of Facility	ome		
_	20 E E G		John Myche			P.O. Box	156, Wa	aldorf, M	D 20604	
О			23a. Part f. Enter the disease, or compleshock, or heart failure. List only o	ications that caused the cause on each line	he death. Do not en	ter the mode of dyir	ng, such as cardia	c or respiratory arre	est,	Approximate Interval Between
基	Physician		Immediate Cause (Final disease or condition	Pa	summe	à				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):	0				
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	ed sit	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequence of):	0				
	and and I-tran	Examin	that initiated events resulting in death) Last	Due to (or as a	consequence of):					
8760,	cate be executed physician and the burial-transit	aiE		000 10 (01 00 0	3311334431133 31).					
387	phy the	dicai		d						* 5111
×	The law requires that the death certific te has been signed by the attending p page 2 should be detached for use as	/We	IF FEMALE:	23c. If yes, outcome of	pregnancy				23d. Date of	delizare
Вох	atter I for u	Physician/M	in the past 12 months?	1 Live birth 2 4 Pregnant at tir	Fetal death 3	Ectopic pregnancy Other (specify)	′		Month	Day Year
0	that the de led by the a detached t	ıysi	1 Yes 2 No 9 Unknown	9□ Unknown						
σ.	res that igned b be deta		Part II. Other significant conditions co	ntributing to death but	not resulting in the u	nderlying cause giv	en in Part I.	23e. Did tob	acco use contribute	e to the cause of death?
ds	puires n sign	d by	Dementio	Hynothy	rorden			1 🗀 Ye	s 2□No 3□	Probably Dunknown
CO	w requir been si should I	iete						24a. Was ar	24h Were	autopsy findings available
Records,	The lay	Completed						autops	y prior	to completion of cause of
		e C	25. Was case referred to medical				00 Pl ( P		No 1 Y	/es 210 No
>	Physician: this certific ral director,	0 B	examiner?		2 ER/Outpatier	nt 3□ DOA Oth		ath <i>(Check only one</i> Home 5 ☐ Reside		
	ding Phy h. After thii funeral c	H	27. Manner of Death	28a. Date of Injury	28b. Time o	f 28c. Injur	v at	28d. Describe ho		pecity)
ion	Attanding ir death. actor: After by the funer	atio	Natural 5 Pending investigation	(Month, Day )	rear) Injury	Wor M 1 □	k? Yes 2 □No			
Division		ifica	3 Suicide 6 Could not be determined		/- At home, farm, str	eet, factory, office	155	28f. Location (Str	eet and Number or	Rural Route Number,
	s after s after of in by	Certification:	4 Nornicide	building, etc.	(Specify)			City or Town	, State)	
	To the Hospital or within 24 hours afte To the Funaral Diractor Completely filled in the Funara Diractor Completely filled in the Funara Diractor Completely filled in the Funara Diractor Completely filled in the Funara Diractor Completely filled in the Funara Diractor Completely filled in the Funara Diractor Completely fil		29a. Certifier (Check only 2 Medical Exami	sician: To the best of	my knowledge, deat	h occurred at the tin	ne, date and place	a, and due to the ca	use(s) and manner	as stated.
	To the Ho within 24 i	edical	one)	ner: On the basis of e	xamination and/or in id.	vestigation, in my o	pinion, death occi	irred at the time, da	ite and place, and o	due to the cause(s)
	To To t	Σ	29b. Signature and title of certifier	1		29c. Licens		29	d. Date signed (Mo	_
•			form Candon or			01	9917		3/11/0	>
1	0 \		30. Name and address of person who co	omplited cause of a	th (Item 23a) (Type,	Print)				
J	B と		Dr. James C. Boyd				MD 20636			
	Sta	4	31. Date filed (Month, Day, Year)	32. Redistrar	s Signature	Coarts 1				
	Registr	ar -	MAR 1 4 2	UUJ JARAGE	and my	STATE OF THE PARTY				

		,	1 - State State Registrer		artment of Health and I rtificate of Death		riene 005	10367
	Physici	an.	Decedent's Name (First, Middle, Last)			2. Date of Deal Month	th Day Ye <i>a</i> r	3. Time of Death
	/Medic			WITT		MARCH	07,2005	1:20 P M
	Examin	er	4a. Facility Name (If not institution, give street and r		4b. City, Town, or Location of Death	1	4c. County of Death	1
	Funeval		Frostburg Village Nursi 5. Social Security Number 6. Sex	ng Home 7. Age (In yrs. last birthday)	Frostburg If Under 1 Year   If Under 24 Hrs.	8 Date of Birth	Allegany	nplace (State or Foreign
	Funeral Director		212 24 2449 1 M 2 X F	86 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) Col	t Virginia
	pu ,		Usual Residence of Decedent  10a, State 10b, County	100 City Town and			TWEST	
	anylan ehow	ō.	MD Allegany	Frostburg				10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	the N	Director	10e. Street and Number	170370000	10f. Zip Code	1	0g. Citizen of What Co	
	3a or		One Kaylor Circle		21532		USA	,
	deat	Funeral	11. Marital Status 12. Was De	cedent Ever in U.S. 13. Forces?	Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - Amer	
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Ö	d within 72 hours after death with the Maryland jene. r than "natural", or items 23a or 28s-f ehow It a MJic. Exh. il reft ast be ruillis d at	ed b	3  Widowed 4 □ Divorced Year or  15. Decedent's Education		dent's Usual Occupation		16b. Kind of Business/I	hite
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yla	2 should be and Mental is marked aumatic ev	卢	Edwin Clarence Nessenge			la Wagne		
Baltimore, Maryland 21215-0036	ges 1 and 2 should be filed tof Health and Mental Hyg If item 27 is marked othe or other traumatic event,	H	19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and Number or Ru			ip Code)
ē,	of Health item 27 other tra		Donald L. Messenger, ne 20a. Method of Disposition	20b. Place of Dispo	Windy Love, Pyrdu	Date PA	155-75 20c. Location - City or 1	own, State
MO	permit. Pages 'Department of H Important: If ite any injury or of		XXBurial 2 ☐ Cremation 3X☐ Removal from `4 ☐ Donation 5 ☐ Other (Specify)		natory or other place) LL Cemetery 3-10	-2005	Hyndman. PA	1
alti	permit. Departm Importa any inju		21. Signature of Funeral Service Licensee	22	2. Name and Address of Facility			
m	P P P P P		Leigh	— Н	arvey H. Zeigler	Funeral	Home, Hyndn	nan, PA
Ĭ,	₩1		23a. Part1. Enter the disease, or complications tha shock, or heart failure. List only one cause or	t caused the death. Do not ent neach line.	er the mode of dying, such as cardiac	or respiratory arre	est,	Approximate Interval Between
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	/Medical Examiner		Due t	o (or as a consequence of):				
	100	er	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	o (or as a consequence of):				
	cuted	Examiner	that initiated events					
Ö,	e exe ian ar urial-t		resulting in death) Last Due to	o (or as a consequence of);				
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dicai	d					
9 x	leath certific attending p	/Me	IF FEMALE: 23c. If yes. o	outcome of pregnancy	No.		22d Date of dala	
Вох	death a atter d for u	iciar	in the past 12 months?	birth 2 Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of deliv	Day Year
P.O.	that the de led by the a detached t	hysi	9 Unknown 9 Unk					
	res tha igned be del	by Physician/Me	Part II. Other significant conditions contributing to		nderlying cause given in Part I.	23e. Did tob	pacco use contribute to	
ord	w require been si should b	ted	Dementia, con	romic ouspir	ration,	1 🗆 Ye	s 2 No 3 Pro	bably 4 Unknown
Vital Records,	e law has b	Completed	CHF. Diabel	es melli	tis COPD	24a. Was ar autops	y prior to co	opsy findings available ompletion of cause of
alF						perform 1 Tes 2	ned? death? No 1 ☐ Yes	2□ No
5	ysician: The is certificate hadirector, page	o Be	25. Was case referred to medical examiner?  1 Yes 2 No Hospital:	Inpatient 2 ER/Outpatien	0.1	th (Check only one	e) ince 6 □Other (Speci	4.1
jo L	ig Phy ter thii neral o	n: T	27. Manner of Death 28a. Dat	e of Injury 28b. Time of Injury Injury			w injury occurred	19)
sior	andin sath. or: Aft he fur	atio	2 Accident investigation	man, bay roar, mijury	M 1 Yes 2 No			
Division of	l or Attanding latter death. Diractor: After	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Plant buil	ce of Injury - At home, farm, str Iding, etc. (Specify)	eet, factory, office	28f. Location (Str City or Town	reet and Number or Rur , State)	al Route Number,
	pital ours a eral C		29a, Certifier 1X Cartifying Physicien: To ti	he heat of my keepyledge, doest	n annuared at the time data and class			
	To the Hospital or Attanding Physician: whim 24 hours after deals. To the Funeral Director: After this certifica completely filled in by the funeral director.	Medical	(Check only 2 Medical Examinar: On the	basis of examination and/or in- tinner stated.	n occurred at the time, date and place, vestigation, in my opinion, death occur	red at the time, da	iuse(s) and manner as s ite and place, and due t	to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier	FD 50	29c. License number		9d. Date signed (Month,	
)	1		) ( for	dling HW	D14464		03-08-2	.005
Ta	mena Taylor	7	30. Name and address of person who completed ca		· ·			~
	nes		S. L. Sandhir, 48 Tarn  31. Date filed (Month, Day-Year)	Terrace, Frost Registrar's Signature	tburg, MD 21532			
	Sta Registr			Joseph Some	K)			

or pu me

		State of Maryland / Department of Health and M Certificate of Death	rentai mygien Reg. N		
	Physician	1. Decedent's Name (First, Middle, Last)  Thomas James Wotring	2. Date of Death Month D March 12,	Day Vear	3. Time of Death 8
04	/Medical Examiner	4a Facility Neme (If not institution, give street and number)  4b. City, Town, or Lo		c. County of Death	
1		Devlin Manor Health Care Center Cumber	rland	Alleg	any
	Funeral Director	5. Social Security Number 214-05-4411  6. Sex 1 N 2 F  7. Age (In yrs. last birthday) 1 Yrs.  7. Age (In yrs. last birthday) 1 Yrs.  7. Age (In yrs. last birthday) 1 Yrs.  7. Age (In yrs. last birthday) 1 Yrs.  8 Hours Min.	8. Date of Birth (Month, Day, Yea 11/28/190)		ace (State or Foreign try) : Virginia
	DC	Usual Residence of Decedent  10a. State 10b. County 10c. City. Town or Location		10	Od. Inside City Limits
	Aarylar r show or	MD Allegany Cumberland			1 ☐ Yes 2∏ No
	with the Maryis a or 28a-f sho by numed I Director	10e. Street end Number  10404 Christie Road, N.E.  21502	10g. C	Citizen of What Coun	try?
020	72 hours after death with the Maryland natural; or items 23s or 28s-1 show dical Examiner must be notified at each by Funeral Director	11. Marital Status  12. Was Decedent Ever in U,S. Armed Forces?  1 Never Married 2 Married  1 Yes, Give  1 Ves or Dates:  13. Was Decedent of Hispanic Origin? (Spe if Yes, specify Cuban, Mexican, Puerto if Yes, Give if Yes, Give if Yes or Dates:	ecify Yes or No- Rican, etc.)	14. Race - America Black, White, of Specify:	
21215-0020	ed within 72 hours ygiene. ior than "natural", it, it a Medical Ex.	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) 11  16a. Decedent's Usual Occupation (Give kind of work done during most of work) life. DO NOT use retired)  Co-0wner		Kind of Business/Ind	lustry
2	Hygier ther there		e (First, Middle, Maide		g Kange
anc	Duid be filed Mental Hyg arked othe atic evant, TO BE C	Clarence Orestus Wotring Lillian		·	ennington
2	12 should be 12 should be 12 marked of 13 marked of 14 marked of 15 marked of 16 marked of 16 marked of 10 marked of	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rura		_	
	ges I and 2 should be filed to of Health and Mental Hyg if item 27 is marked other or other traumetic event, To Be C	Agnes L. Stemple/ daughter 789 Burnside Drive, G			
e,	of Hei	20a. Method of Disposition 20b. Place of Disposition (Name of		Location - City or To	
E	0 5 # 5 0 6 # 5	1 Donation 5 Other (Specify)  1 Donation 5 Other (Specify)  1 Donation 5 Other (Specify)	3/16/2005	Cumberlan	d, MD
Baltimore,	permit. Peges 1 and Depertment of Health Important: if item 27 any injury or other ti pnce.	21. Signature of F. e. Il Service Licensee  22. Name and Address of Facility Address o		•	Home, P.A. 21502
	Physician	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac c shock, or heart failure. List only one cause on each line.	or respiratory arrest,		Approximate Interval Between Onset and Death
	/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  a. (application of the condition of the con			nous
68760,	moste be executed g physician end as the buriel-transit ledical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b.	ine		years
Вох	use use	d		<u> </u>	
00	death	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.	23b. Did tobaco	co use contribute to	the cause of death?
s, P.O	v requires that the death centri been signed by the attending should be deteched for use a ieted by Physiclan/Me	Osterporosis	1 TYes	2□ No 3□ Prob	eably 4 ☐ Unknown
Vital Records,	§ 85 ℃	,	24a. Was an au performed?	ava	ere eutopsy findings allable prior to npletion of cause death?
= '	Ine law ate has t page 2 s		1 ☐ ¥66	200 No 12	Yes 2 No
/ita	sician: The law certificate has t lirector, page 2 s o Be Compli		h (Check only one)		
ot o	ald ald		me 5 Residence 28d. Describe how in		)
5	To the hospital or Arending Printin 24 hours effer death.  To the Funeral Director: After the completely filled in by the funeral Medical Certification:		28f. Location (Street City or Town, Sta		l Route Number,
	I o the hospital of An within 24 hours effect To the Funaral Direct completely filled in by Medical Certifi	23a Certifier (Check only one)  12 Certifying Fhyeician: To the best of my knowledge death occurred at the time, date and claims and manner stated.			
:	within 2 vithin 9b. Signature and title of certifier 29c. License number	29d. [	Date signed (Month, I	Day, Year)	
<b>)</b>	- > = 0	Downson Celle m D0054411		March 14,	2005
,	nks_	30. Name and address of person who completed cause of death (Item 23a) (Type, Mint) Beverly M. Calkins, M.D. 500 Memorial Avenue, Cu	umberland,	MD 2150	2
	State Registrar	31. Date filed (Month, Day, Year)  MAR 1 4 2005  33 Registrar's Signature			

DHMH 16 Rev 6/95

			1 - For State Registrer	State of Ma	arylan	-	artment of l		Mental Hy	giene	200	5	10369
	q	, -	Decedent's Name (First, Middle, Last	st)					2. Date of De		Va		. Time of Death
	Physicia		CHARLES THURST	ON WELLER	}				Month March	Day 6 ,	2005		0:45 A M
	/Medic Examin		4a. Fecility Name (If not institution, give	street and number)			4b. City, Town,	or Location of De	ath	4c.	County of D	eath	
			FREDERICK MEMOR	IAL HOSPIT	'AL		FREDE	RICK		I	FREDER		
	Funeral		5. Social Security Number 6. S	ex 7. Ag		ast birthday)	If Under 1 Year Months Days			th v. Year)	9. 1	Birthplace Country)	State or Foreign
	Director			M 2□F		95 Yrs.			June 1	4, 19	909 Fr	eder	ick
	pug *		Usual Residence of Decedent  10a. State 10b. County		10c. City	/, Town or Lo	cation					10d.	Inside City Limits
	lanyli sho	ō	Maryland Frederic	ck		ederic							1∭Yes 2☐No
	the A	ect	10e. Street and Number				10f. Zip Code			10a. Citi	zen of What	Country?	)
	with with	ä	5543 Etzler Road				2170	2		-	. S. A		
	ns 23	Funeral Director	11. Marital Status	12. Was Decedent	Ever in U.	S. 13.			(Specify Yes or No erto Rican, etc.)	-	14. Race - A	merican I	Indian,
2	r Iter	표	1 ☐ Never Married 2 🗓 Married	Armed Forces? 1 XYes 2 If Yes, Give	No Ari	ny			erto Rican, etc.)		Black, W		
3	be filed within 72 hours after death with the Maryland Hygiene. A let Hygiene. do ther then "naturel", or flems 23a or 28e-f show event, the Medical Evantral must be righted as	by	3 Widowed 4 Divorced	Year or Dates:	ww 2		1 □ Yes 2 □XNo	Specify:			Specify:	Whi	te
ם כ	72 ho	Completed	15. Decedent's Ed (Specify only highest gra	ducation		16a. Dece	dent's Usual Occu	pation during most of v	vorking	16b. Kii	nd of Busine	ss/Indust	ry
V	ifthin 19.	nple	Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT use retin	ed)				_	
V	ygier ygier nertt	Cor	10th Grade			Natio	nal Grid		.1st lame (First, Middle		ectric	al	
2	be first H H d ott	Be	17. Father's Name (First, Middle, Last) William Walter V						Holmes	, waluen	Sumame)		
y Z	d Mer narke	L <sub>0</sub>				10b Maili	a - Address /Ctros		Rural Route Numb	or City o	r Tourn Stat	o Zin Co	de)
<u> </u>	12 st h and 7 Is n treun		19a. Informant's Name/Relationship (  Judith H. Leaman		er				ederick,			217	
ב ט	Healt The The		20a. Method of Disposition				osition (Name of matory or other pla		Date		cation - City		
2	ages nt of n		1 Burial 2 TCremation 3 5	Removal from State					2005				
ballillore,	it. Partmentintent		4 □ Donation 5 □ Other (Specification 21. Signature of Funeral Service Licer				Cremato						Virginia
ช <b>ด</b>	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If time 27 is marked other then "naturel; or Items 23a or 28e-f show any injury or other treumatic event, the Medical Examinat must be instiffed at once.		Down (d)	X tottle		D D	anzansky	-Goldber	g Memori ke, Rock	al Ch	napels	, In	d 20852
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause	d the death	h. Do not ent	ter the mode of dy	ing, such as card	liac or respiratory a	rrest,	-, IIGI	Ap	proximate
			shock, or heart failure. List only Immediate Cause (Final									Or	erval Between nset and Death
	Pnysician /Medical		disease or condition resulting in death)	aDue to (or as		ENZA							
	Examiner			200 10 (01 00	a consoq	201100 017.							
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Ulscass of Injury	b. Due to (or as	a conseq	uence of):							
,00,	ate be executed hysician and he burial-transit	I Exar	that initiated events resulting in death) Last	Due to (or as	a conseq	uence of):							
0	ate b physic the b	dical		d									
00 X	ding p	/Me	IF FEMALE:	23c. If yes, outcome	of pregna	ncv					22d Data of	dolinosa	
. DOX	w requires that the death certifica been signed by the attending ph should be detached for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No	1 Live birth 4 Pregnant a	2 Feta	I death 3	□Ectopic pregnan □ Other (specify)	су		•	23d. Date of Month	Day	y Year
Э	at the	Phy	9 Unknown			167	4.4.	and the Position	00: 5::	toboss		o to the	aura of doash?
'n	es th igned be de	by	Part II. Other significant conditions			-	inderlying cause g	iven in Part I.					ause of death?  y 4 Unknown
0	equir sen s sould	ted	Congestive Atherosch	CANOTOW	ic Op	19100	X		- '-	Yes 2	<b>X</b> 10 3 □	] Probably	y 4 DOTKHOWN
Records	icien: The law requires that the death certificate certificate by the attending physector, page 2 should be detached for use as the	Completed	Athoroscu	erotic C		4~>_	HEART I	nsease	24a. Was auto perf 1 🗆 Yes			to comple	findings available etion of cause of
		O	25. Was case referred to medical					26. Place of D	Death (Check only				
_	Physicien: this certific ral director,	To B	examiner? 1 □ Yes 2 XNo	Hospital: 1 Inpati	ent 2 🗆	EP/Outpatie	nt 3□ DOA O	ther: 4 🗆 Nursing	g Home 5□Res	idence (	6 □Other (5	Specify)	
00 00	ding Phys th. : After this funeral dir		27. Manner of Death 1 Natural 5 Pending 2 Accident investigatio	28a. Date of Inju (Month, Da	ury ay Year)	28b. Time of Injury	W	ury at ork? □ Yes 2 □ No	28d. Describe	how injur	y occurred		
DIVISION	al or Attending F s after death. I Director: After d in by the funer	Certification:	3 Suicide 6 Could not be determined		jury - At ho tc. (Specif	ome, farm, st	reet, factory, office	- 410	28f. Location City or To	Street an wn, State	d Number o	r Aural Ad	oute Number,
	To the Hospital or Al within 24 hours after or To the Funerel Direct completely filled in by	Medical Co		nysicien: To the best miner: On the basis of and manner s	of examina								
	o the o the omple	Mec	29b. Signature and title of certifier	23 (112/11/31/3)			29c, Licer	nse number		29d. Dat	e signed (M	onth, Day	/, Year)
	⊬ ≱ ⊬ ŏ			1 Hunde	mar	ws	D	39440	4	~	1610		
	10		30. Name and addless of person who	,			100	REN HI	Hondome	25	1010		
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DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)
MAR 1 1 2005

David P. Wheeler Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05 - 1552State of Maryland / Department of Health and Mental Hygiene **AKG** State Registra Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month Day **Physician** 2005 11:30 March 1 David Phillip Wheeler /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Baltimore City 5715 Park Heights Avenue #706 Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 XM 2 ☐ F Yrs. Jan 17, 1939 Washington, Director 578-50**-**7075 Usual Residence of Decedent death with the Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits Show r then "natural", or items 23e or 28a-f shorter Medical Exercipant by natified at 1 XYes 2 No Director Baltimore City **Baltimore** Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5715 Park Heights Ave 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: Korea Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ 3 Widowed 4 Divorced Black Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Security Enforcement Lieutant permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: It itam 27 is markad othar any injury or othar traumetic evant, i 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Anthony Hillary Wheeler Viola Cummingham ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phillip David March/Son 1151 Pointclear P1, #1525, Huntsville, AL 35824 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Crematory Mar 10, 2005 Baltimore, MD 22. Name and Address of Facility Hines-Rinaldi Funeral Home 21. Signature of Funeral Service Licensee 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause on each line. Approximate Interval Between perteinsive Evote Cardiovascula Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? Day 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 3 Probably 4 DNnknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ✓ Yes 2 ☐ No 2 🗌 No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other 4 Nursing Home 5 Residence Set ther (Specify) at SCOLO 2 1X Yes 2 No this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: After (Month, Day Year) Injury To the Hospital or Attending 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by determined 4 \( \text{Homicide} within 24 hours a To tha Funaral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State Registrar

2

31. Date filed (Month, Day, Year) 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

egistrar's Signature

29c. License number

OCME

111 Penn Street

29d. Date signed (Month, Day, Year)

Baltimore, Maryland 21201

March

2, 2005

			For State	State of		nd / Dep	artment c	f Health an			_	10371
			Registrar			Ce	rtificate (	of Death		Reg. I	No.	100/1
	Physicia /Medic		Decedent's Name (First, Middle, SEYMOUR	, Last)		WOLF			2. Date of Month MARCH		Day Year 2005	3. Time of Death  10:55 A <sup>M</sup>
	Examin		4a. Facility Name (If not institution,	give street and nun	nber)		4b. City, Tov	n, or Location of D	Death		4c. County of Dea	ith
ı			MANOR CARE				I	POTOMAC				NTGOMERY
	Funeral Director		054-10-0014	6. Sex 1	7. Age (in yrs.	87 Yrs.	If Under 1 Y Months Da		Hrs. 8. Date of 1 (Month, 04 / 27	Birth Day, Yea /191	ar) 9. Bin C NEW	thplace (State or Foreign ountry) VYORK
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or L	ocation					10d. Inside City Limits
	Aaryli f sho	ō		BEACH				GARDENS				1 TYes 2 □ No
	the 28a-	rect	10e. Street and Number	DLAGII		1 21111	10f. Zip Co			10g.	Citizen of What C	ountry?
	h with	i D	101 PALM BAY CIT	RCLE APT	T D			33418			U.S.A.	
	deatl	ner	11. Marital Status	12. Was Dece Armed For	dent Ever in U	J.S. 13.	Was Decedent	of Hispanic Origin' Cuban, Mexican, P	? (Specify Yes or	No-	14. Race - Am Black, Whi	
39	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f ehow ha Madical Examiner must be notilited at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced		2□No W	WII		No Specify:	dono moan, die.		Specify:	WHITE
Ö	2 hou	ted	15. Decedent	s Education		16a. Dece	dent's Usual O	ccupation	(odrin a	16b	Kind of Business	/Industry
215	thin 7 e. an "n Med	ple	(Specify only highest Elementary/Secondary (0-12)	College (1	-4or 5+)	life.	DO NOT use re	,	working			
2	ed wil	Con		5-		VETER	INARIA					HOSPITAL
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants: if item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ourse.	o Be	17. Father's Name (First, Middle, LEZRA WOLF	.ast)					Name (First, Midd BERNSTEI		len Sumame)	
ary	shou and N		19a. Informant's Name/Relationsh	nip (Type, Print)		19b. Maili	ng Address (St	reet and Number o	or Rural Route Nur	nber, Cit	y or Town, State,	Zip Code)
Σ	and and a salth n 27 i		ROSLYN D. WOLF-V	VIFE		_		CONTRACTOR OF THE PARTY OF THE		-		ENS,FL 33418
ore	Of He ite		20a. Method of Disposition 1   Burial 2 □ Cremation	3 Removal from		Place of Dispecemetery, cre	osition (Name o matory or other	of r place)	Date	20c.	Location - City or	Town, State
Ē	Pag tment tant: jury		'4 □Donation 5 □ Other (Sp	ecify)		G DAVI	D MEML	GDS 3/	11/2005	FAL	LS CHURC	CH, VIRGINIA
Baltimore,	Depar Depar Impor any in		21. Signature of Funeral Service L	Xtote	Terry	10	91 ROCE	AGEL FUNE VILLE PI	KE. ROCK	$\mathtt{VILL}$	N, INC. E, MARYI	AND 20852
			23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that conly one cause on e	aused the dea ach line.	th. Do not en	ter the mode of	dying, such as car	rdiac or respiratory	arrest,		Approximate Interval Between
20	Physician		Immediate Cause (Final disease or condition		NIC REN							Onset and Death 3 YEARS
	/Medical		resulting in death)	a	or as a conse							10.203
	Examiner	L	Sequentially list conditions,		RTENTIC							10 YEARS
	ed sit	ine	Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury	Due to (	or as a consec	quence of):						
	be executed icien and burial-transit	Examiner	that initiated events resulting in death) Last	c	or as a consec	quence of):						
760,	ate be executed nysicien and he burial-transit	calE										
687	tificate og phys as the			d								
Box	leath certificat ettending phy i for use as th	n/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of pregn	ancy	Testania arasa	2004			23d. Date of de	livery
-	that the death led by the etter detached for i	by Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No		ant at time of		⊒Ectopic pregn ⊒ Other (specif			-	Month	Day Year
P.0	at the	hys	9 🗆 Unknown		700							
Vital Records,	26 PG		Part II. Other significent conditio	ns contributing to de	eath but not re	sulting in the i	inderlying caus	e given in Part I.				o the cause of death?
00	s been si	olete							24a. W		24b. Were a	utopsy findings available
Re	The law	Completed							— au pe 1 □ Yes	topsy rformed	? death?	completion of cause of s 2 2 No
ita		BeC	25. Was case referred to medical					26. Place of	Death (Check on			
	<b>8</b> .⊴ <del>8</del>	To	examiner? 1 ☐ Yes 2 No	Hospital: 1 □ I	npatient 2	ER/Outpatie	nt 3□ DOA	Other: 4 Nursin	ng Home 5□Re	sidence	6 □Other (Spe	ecify)
n of	ding Ph h. Atter th tuneral	on:	27. Manner of Death  1X Natural 5 ☐ Pending	28a. Date of (Mont	of Injury h, Day Year)	28b. Time of Injury		Injury at Work?		e how in	njury occurred	
sio	Attending r death. ector: After by the funer	cati	2 Accident investig	ation			М	1 ☐ Yes 2 ☐ No		(2)		
Division	after d after d Direct d in by	Certification:	4 Homicide determi	ned 289. Place	of Injury - At h ng, etc. (Speci		reet, factory, of	fice	City or	Town, St	and Number or H ate)	lural Route Number,
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Medical C		g Physicien: To the Examiner: On the ba								
	To the within 2 To the complet	Mec	29b. Signature and title of certifier		ioi stateu.		29c. Li	cense number		29d.	Date signed (Mon	th, Day, Year)
			> Anatha	<u>n</u>			DO	053615		N	MARCH 10	, 2005
•	v		30. Name and address of person of ARUNA NATHAN, M	who completed caus	e of death (Ite	m 23a) (Type / T.T.F. T	Print)	O8. ROCKV	/ILI.E. MA	RYL.	AND 2085	52
			31. Date filed (Month, Day, Year)					oo, Rook v				
	Sta Registi		MAR 11	2005	egistrar's Sign	& A	ali					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Phillip H. White State of Maryland / Department of Health and Mental Hygiene

1- State Unpend Item 23a,27,28a-f per me 6841 3-28-05 tas

Reg. No. 05 - 1836AKG Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death March 12<sup>Day</sup> 2005<sup>Year</sup> **Physician** PHILLIP Η. WHITE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Catonsville Baltimore 6 Shipley Avenue If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. | 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) **Funeral** 1₩ 2□F Director 217-94-6071 Maryland 30 Nov.23,1974 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23e or 28e-f show amy injury or other treumatic event, the Medical Evantinating the rotified at once. Director MD Baltimore Catonsville 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 Shipley Avenue 21228 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Mever Married 2 Married ☐Yes Z☐No Baltimore, Maryland 21215-0036 1 ☐ Yes XXX No Specify: Yes. Give Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hilton Hotel Custodian 2 yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Phillip H. White, Sr. Minnie V. Jackson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Raymond L. Jackson (Brother) 409 Gaither Ave., Catonsville, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) Locust Church Cem 3/21/05 Columbia, MD 22. Name and Address of Facility Snowden Funeral Home, P.A. 21. Sim rure of Funeral Service License 246 N. Wash. St., Rockville, MD 20850 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Immediate Cause Final disease or condition resulting in death) **Physician** Intoxication And Cocaine Use a <u>Heroin</u> /Medical Due to (or as a consequence of). **Examiner** 

Sequentially list conditions, if any, leading to immediate caus. Enter Uncorpy of Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant

in the past 12 months? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical

1 Yes 2 No

examiner?

27. Manner of Death

1 Natural

2 Accident

4 Homicide

3 Suicide

29a. Certifier

Examiner

Physician/Medical

þ

Be Completed

Certification: To

Medical

IF FEMALE

burial-transit

the

esn

jo

ed by the a

director,

filled 24 hours

completely

0

this

death.

To the within 2

after death Director:

attending

Hospital or Attanding Physician: The law requires that the death certificate be executed

Box 68760.

P.O.

of Vital Records.

Division

Due to (or as a consequence of): Due to (or as a consequence of):

If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 4□Pregnant at time of death

3 ☐ Ectopic pregnancy 5 ☐ Other (specify)

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death?

Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.

9 Unknown

1 Yes 2 No 24a. Was an autopsy performed?

3 ☐ Probably 4 ☐ Unknown

Approximate Interval Between Onset and Death

4:04 P M

10d. Inside City Limits

Yes 2 No

Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 2 Yes 2 \( \subseteq \) No

26. Place of Death (Check only one)

Other 4 Nursing Home 5 Residence 6 Dother (Specify) at Scene 28d. Describe how injury occurred

28a. Date of Injury **Formal**, *Day Year)*  **3-12-05** Found At 3:45 PM investigation 6 X Could not be determined

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Found at Residence

28f. Location (Street and Number or Rural Route Number City or Town, State) **6 Shipley Avenue** Catonsville, Maryland

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29b. Signature and title of certifier

OCME

28c. Injury at Work?

29d. Date signed (Month, Day, Year) March 13, 2005

111 Penn Street Baltimore, Maryland 21201

1 ☐ Yes 🛣 No

State Registrar 31. Date filed (Month, Day, Year) 2005

**ORIGINAL** 

DHMH 17 Rev 1/2001

			For State Registrar	State of M	aryland / Dep <i>Ce</i>	ertificate of		The state of the s	giene Reg. No. 2 11 (	15 10272
	Physicia /Medic		Negdata  1. Decedent's Name (First, Middle, Las  IRMA ADLE	-				2. Date of De Month 03	ath Day	Year 9.30 k M
	Examin	er	4a. Facility Name (If not institution, give POTOMAC VALLEY	NURSING	AND WELLN		RR	OCKVILLE		GOMERY
	Funeral Director		212-34-0709	ex 7. Aç □ M 2☐ F	ge (In yrs. last birthday 80 Yrs.	Months Days		Novembe	th er 17,192	9. Birthplace (State or Foreign Country) 4 Germany
	within 72 hours after death with the Maryland ene. then "natural", or Itama 23a or 28a-f show the Malfail Examilrer must be notified at	ector	Usual Residence of Decedent	ery	10c. City, Town or I	е			10g. Citizen of Wh	10d. Inside City Limits 1
	eath with t	Funeral Director	1235 Potomac Val	ley Road	Ever in II S 13	10f. Zip Code 20850 . Was Decedent of H	dispanie Origin	(Specify Yes or No	USA	- American Indian,
980	urs after de al', or Itam Exculter	by	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	Armed Forces'  1  Yes 2  If Yes, Give Year or Dates:	?	If Yes, specify Cuba	Specify:	uerto Rican, etc.)	Black	White, etc. German
Maryland 21215-0036	s within 72 ho piene. r than "natur rre M. vilcal I	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		5+) (Giv	edent's Usual Occup e kind of work done DO NOT use retired	during most of d)	working	16b. Kind of Bus	
land 2	be filed ttal Hygi of other evant, I	To Be Co	17. Father's Name (First, Middle, Last) Fritz Wetzel			103   0, 30	18. Mother's	Name <i>(First, Middl</i> e Hoffman	, Maiden Sumame	
	12 7 15 tra		19a. Informant's Name/Relationship ( Brigitte Steinho			ling Address (Street Leekes Le				
Baltimore,	Pages 1 and nent of Healt int: If Itam 2 iry or other		20a. Method of Disposition  1. Purial 2 □ Cremation 3 □  4 □ Lonation 5 □ Other (Specification	Removal from State	20b. Place of Dis cemetery, cr Howard	oosition (Name of ematory or other plac Universit		rch 16,20		shington,DC
Balti	permit. Pages. Department of It Important: If Its any Injury or of once.		21. Signature of Funeral Service Licer	2/		3821 14th	Street	NW Washi	naton DC	20011
	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that caus one cause on each CARDI	dd the death. Do not e line. OPULMONA	nter the mode of dyir	ng, such as car	diac or respiratory a	rrest,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)  Sequentially list conditions,	PNE PNE	s a consequence of):					
,8760,	cate be executed by siclan and the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	s a consequence of): s a consequence of):					
P.O. Box 68	ath certific attending p for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown		2 Fetal death 3	Ectopic pregnanc	у		23d. Date Mont	of delivery h Day Year
rds, P	quires that the de n signed by the a uld be detached i		Part II. Other significant conditions of SENILE DEM	entributing to death	but not resulting in the	underlying cause giv	ven in Part I.	23e. Did 1		oute to the cause of death?  B Probably 4 Unknown
of Vital Records,	The law requested has been page 2 should	Completed by	SEIZURE DISC	RDER				24a. Was auto perfo 1 Yes	psy pr prmed2 de	ere autopsy findings available for to completion of cause of lath?
Vita	Phyaician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	ient 2 ER/Outpati	ent 3 DOA Oth		Death (Check only		· /Cif-th
ion of	attanding Physideath. ctor: After this y the funeral di	atlon; To	27. Manner of Death Natural 5 Pending 2 Accident investigation	1 ☐ Inpat  28a. Date of Inj (Month, D		of 28c. Injur			how injury occurre	
Division	To the Hospitel or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not b 4 Homicide determined	280. Place of II	njury - At home, farm, etc. (Specify)	street, factory, office			Street and Numbe wn, State)	r or Rural Route Number,
	To tha Hospital or A within 24 hours after To the Funeral Dires completely filled in by	Medical	29a. Certifier (Check only one) Certifying Physics Medical Exer	nysician: To the bes niner: On the basis and maneer s	t of my knowledge, de of examination and/or stated.	ath occurred at the ti investigation, in my o	me, date and p opinion, death o	lace, and due to the occurred at the time,	date and place, ar	nd due to the cause(s)
	To the within To the Comp	×	29b. Signature and title of certified			29c. Licens	se number 0 6 1 9 5	9	29d. Date signed 03   15	(Month. Day, Year) 2005
į	10		30. Name and address of person who	9 LAMBER	CTON DR G	e, Print)		MD 209		
	Sta Regist		31. Date filed (Month, Day, Year)	05 Chara	trar's Signature	arle				

			State of Maryland / Departmen  1 - State Amend Item 24a per Verb., G843	t of Health and Me	ental Hygier	21105	10374
	Physici /Medio	al	1. Decedent's Name (First, Middle, Last) Alexander William Brown		morch 1	Day Year	3. Time of Death 8125 PM
	Examir	er		Town, or Location of Death <b>erstown</b>		tc. County of Death Washingto	on
	Funeral Director		5. Social Security Number 129-24-5024-A 6. Sex 7. Age (In yrs. last birthday) Months 73 Yrs.	1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth Month Pay, 8ea August 8,	9. Birthp	lace (State or Foreign nto, Canada
	show	ō	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  PA Franklin Blue Ridge Su	mm <b>i</b> †		1	0d. Inside City Limits  ₩3¥Yes 2 □ No
	with the A 3a or 28a-1	Funeral Director	10e. Street and Number 13435 Pennersville Road			Citizen of What Cour anada	itry?
396	filed within 72 hours after death with the Maryland Hygiene. ther than "neturel", or Items 23a or 28a-f show thit, the Medical Evantrat must be notified at	þ	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  3 Never Married 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Pes 2 No If Yes, Give 1 Year or Dates:	lent of Hispanic Origin? (Specify Cuban, Mexican, Puerto F 2 No Specify:	cify Yes or No- lican, etc.)	14. Race - Americ Black, White, Specify: Ca Ca	
21215-0036	within 72 hou iene. r than "neture the Medical E	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  Oth  College (1-4or 5+)  Miscella	rk done during most of workin se retired)	9	Kind of Business/Ind	lustry
73	should be filed and Mental Hyg s marked othe umatic event,	To Be C	17. Father's Name (First, Middle, Last) Alexander Brown		(First, Middle, Maid Cornell		I 1
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menial Hygiene. Importents it item 27 is marked other than "neturel", or Items 23a or 28a-1 show any injury or other treumatic event, the Madical Examinet must be notified at once.			(Street and Number or Rural nersville Road ne of ther place)	d Blue Ri		t,PA 17214
Baltimore,	permit. Pa Departmen Importent: eny injury once.		*4 \$2 \$3 tonation 5 □ Other (Specify) Howard Med. S  21. Signature of Funeral Service Licensee  22. Name an Austia	chool n Royster Fund 14th Street N	eral Home	shington.	
	Priysician /Medical Examiner	Examiner	23a Part. Enter the disease, or complications that caused the death. Do not enter the mod shock of heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Since the condition of the cause (Disease or injury that initiated events			30113,50 20	Approximate Interval Between Onset and Death  3 Odens 3 Odens
Box 68760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medical Exa	Due to (or as a consequence of):  d.  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1			23d. Date of delive	ery Day Year
s, P.O.	es that the death certific igned by the attending p be detached for use as		1 Yes 2 No 9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying c	14	23e. Did tobacc	o use contribute to the	ne cause of death?
Records,	The law require ate has been sig page 2 should b	Completed by	Meningitis		1  Yes  24a. Was an autopsy performed	24b. Were auto prior to con death?	psy findings available mpletion of cause of
		Be Co	25. Was case referred to medical examiner?	26. Place of Death	1 ☐ Yes 2 ☑ X	No 1 □ Yes	2□ No
ion of Vital	운 두 등	ု	1 Yes 2 No Hospital: 1 Impatient 2 ER/Outpatient 3 DC		ne 5 Aesidence 8d. Describe how in	6 ☐Other (Specifi jury occurred	0
bivision	al or Atte s after dea s Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory building, etc. (Specify)	r, office 2	8f. Location (Street City or Town, St	and Number or Rura ate)	l Route Number,
	To the Hoepital or Attending F within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred 2 Medical Examinar: On the basis of examination and/or investigation and manner stated.	, in my opinion, death occurre	d at the time, date a	and place, and due to	the cause(s)
	To t With To t	Σ		: License number	29d. [	Date signed (Month,	Day, Year)
	Va		30. Name and address of person who completed cau e of death (Item 23a) (Type, Print)  Not Mallow Hours 1150 Professional CF Suite		-u, Mo	- 1 - 1 - 0	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)  MAR 2 8 2005  MAR 2 8 2005				

			1 - For State Registrar	State of Mai		artment of F rtificate of			ene g. No. 2005	10375
	Physici		1. Decedent's Name (First, Middle, La William Calvi	n Brown JR.				2. Date of Death Month March 1	9 <sup>Day</sup> 2005 <sup>Year</sup>	3. Time of Death 8:24 AM
	/Medio Examir		4a. Fecility Name (If not institution, giter Prince Georges			4b. City, Town, o	r Location of Death		4c. County of Death	Georges
	Funeral Director			Sex 7. Age 1 및 M 2 □ F	(In yrs. last birthday) 49 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, November	9. Birth	nplace (State or Foreign untry) Washington , I
	Maryland If show	tor	10a. State 10b. County DC		10c. City, Town or Lo Washin		-			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	h with the 23a or 286	Funeral Director	10e. Street and Number 65 55th Street	SE		10f. Zip Code 200	19		g. Citizen of What Co	
920	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Heath and Mental Hygiene. importent: if item 27 is marked other then "naturel", or items 23a or 28e-f show any injury or other treumatic event, the Medical Examera, must be indiffed at once.	by	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 Tyes 2 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cubin 1 ☐ Yes 2 🗷 No	lispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: Bla	e, etc.
1215-0	vithin 72 ho ne. hen "natur is Medical	Completed	15. Decedent's Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+	)		ation during most of work d)	1	6b. Kind of Business/l	
Maryland 21215-0036	ould be filed within Mental Hygiene. arked other then atic event, The Ma	To Be Co	12th  17. Father's Name (First, Middle, Las William Calvin		DIS	abled		e (First, Middle, M		
, Mary	1 and 2 should be Health and Mental iem 27 is marked i	-	19a. Informant's Name/Relationship BeaNita Brown	(Type, Print)		-	and Number or Rui	al Route Number,	City or Town, State, Z	
Baltimore,	permit, Pages 1 an Department of Heal Importent: If item 2 any injury or other once.		20a. Method of Disposition  1 Burial 2 Cremation 3 Cremation 5 Other (Special Control of		20b. Place of Dispo cemetery, createry Riverdal				oc. Location - City or 5 Riverdal	
Balt	permit. Depart import any inj		21. Signature of Funeral Service Lice			3821 14th	ss of Facility Yster Fur Street N	WW Washin	aton DC 20	
	Physician /Medical		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	Congesti	ve Heart		ng, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death I-2 NYS
3760,	Examiner  a partial-transit	licai Examiner	Sequentially list conditions, if any, leading to animodate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Chronic Due to ( r as a Diabetes	consequence of): Renal Inst Consequence of): Mellitus consequence of):	ufficienc	У			Months
P.O. Box 68	the death certifical y the attending phy ched for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1□Live birth 2 4□Pregnant at ti 9□Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	1		23d. Date of deli Month	very Day Year
		by	Part II. Other significent conditions Hypertension	contributing to death but	not resulting in the u	inderlying cause giv	en in Part I.		acco use contribute to	the cause of death?
Vital Records,	The far ate has page 2	Completed						24a. Was an autopsy perform	ed? prior to c	lopsy findings available completion of cause of
of	ding Physicien: Th h. After this certificate funeral director, pag	tion: To Be	25. Was case referred to medical examiner?  1 ★ Yes 2 No  27. Manner of Death  1 ★ Natural 5 Pending 2 Accident investigatic	Hospital: 1 Inpatient 28a. Date of Injury (Month, Day)	28b. Time o	f 28c. Injur Wor	er: 4 ☐ Nursing Ho	th (Check only one ome 5 Resider 28d. Describe how	nce 6 Other (Spec	offy)
Division	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: Atter th completely filled in by the funeral	Certification:	3 Suicide 6 Could not l	be 200 Place of Injur	y - At home, farm, st (Specify)			28f. Location (Str. City or Town,	eet and Number or Ru State)	ral Route Number,
	he Hospitei in 24 hours a he Funerei I pletely filled	edical	29a. Certifying P (Check only one)  1 Certifying P 2 Medical Exa	hysicien: To the best of miner: On the basis of e and manner state	xamination and/or in	th occurred at the tire to the	ne, date and place, pinion, death occur	and due to the car red at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
2	To the within 2 To the complet	Σ	29b. Signature and title of certifier	Alle, M.	0.	29c. Licens	e number 90796		d. Date signed (Month March 20,	
	7		30. Name and address of person who Albert E. Rolle	, M.D. 600	Riverben	d Road Fo	rt Washir	ngton, MD	20744	
	Sta Registi		31. Date filed (Month, Day, Year) MAR 2 8 20	2. Registrar	's Signature	de .				

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 12:10 P M William Edward Brant 27, 2005 March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 7817 Jamesford Rd. Dundalk If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min. Hours 1 ☑ M 2 □ F Months Days Yrs. 220 40 8095 Director 61 Aug. 10, 1943 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County or than "naturel", or itams 23a or 28a-f show the Medical Exercitive roust be notified at 1 ☐Yes 2 No Dundalk Director Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21222 USA 7817 Jamesford Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give 1960/64 Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married White Saltimore, Maryland 21215-0036 1 Yes 2 XNo Specify Specify: þ 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) e filed within al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Public Safety/ Security Supervisor permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 Is marked othe any injury or other treumatic aucas or other treumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Eleanor Deakins Charles Brant 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7645 Charlesmont Rd. Baltimore, Md. 21222 Kelly Brant (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens Of Faith Cemetery 3/30/2005 Baltimore, Md. \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 21 Signature of Funeral Service Ligansee 1407 Old Fastern Avenue Essex, Md. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. shock, or rear failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Gause (Final disease or condition **Physician** Con disease or conditi resulting in death) /Medical Due to (or as a consequence of) **Examiner** can divoras cintus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner -transit law requires that the death certificate be executed and Due to (or as a consequence of): attending physician a for use as the burial-Division of Vital Records, P.O. Box 68760 Physiclan/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 2 🗌 No ed by the a detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No page 2 2 X No 1 Tes 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 1X Yes 2 □ No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b Time of 27 Manner of Death After 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident the 3 🗀 Suicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after de To the Funerel Directo completely filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 9000 7632 2005

Registrar DHMH 17 Rev 1/2001

State

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31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DUNDALIC AUE

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3altimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2005 Year March 21, **Physician** 11:52 PM Stephen Ρ. Black /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Westminster Carroll Carroll Hospital Center 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F Director Feb. 10, 1964 Pennsylvania 41 219-92-9746 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2√2 No Directo Reisterstown Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zlp Code U.S.A. 21136 216 High Falcon Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HVAC Tech L.H. Cranston & Sons 12 12 should be filed w h and Mental Hygier 7 Is markad other th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Eleanore **Black** E. Pau1 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If itam 27 Is n any injury or other traun 216 High Falcon Road Reisterstown, Maryland 21136 Amanda J. Black 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 3/26/05 Reisterstown, MD All Saints Cemetery ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road Ste Eline Funeral Home Reisterstown, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician INTURIES HULTIPLE /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-transit Due to (or as a consequence of): the attending physician Physician/Medical d the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Įo. Month Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4☐Pregnant at time of death detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1. ✓ Yes 2 □ No 24a. Was an autopsy performed 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 3€ER/Outpatient 3☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1XYes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After Injury 5 Pending investigation 1 Natural DRIVER OF CAR IN COULSION after death.
I Director: Aft 11:12 PM 1 Yes 2 No 3/21/05 2 Accident 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide RT 140 CBALTIMORECO, FINKSBURG, HD ROAD 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

Division of Vital Records, P.O. Box 68760

ANA MO RUBIO MAR 2 8 2005 31. Date filed (Month

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street 32 Aegistrar's Signature

OCME

March 22,2005

Baltimore, Maryland 21201

State

2005

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11	0 + 1		30. Name and address of person who co	ompleted cause of de	eath (Item 2	23а) (Туре.	Print)			-						
			CONRAD MAY A	1.D., 16	) N.	GRE	ENE	ST.	BI	ALT	MOR	EM	D	2/2	C/	
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	Registr	ar	CUUS & & MAIN	DERENAS 1	W. V	30										

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item#10b-c, 10e-f, 19a-b, per INF G842, 4/12705 TT State of Maryland / Department of Health and Mental Hygien 10380 1 - For State Ragistrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2005) 0945 AM **Physician** Bowen MARGARET /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Beltimore Baltimone SITA MargaretEstelle Bower If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months 1 □ M 220-05-835 Director Usual Residence of Decedent tha Maryland 10c. City, Towner earlier City 10d. Inside City Limits 10a State 10 Worcester item 27 is marked other then "naturel", or items 23a or 28e-f show other traumatic event. The Medical Examiner must be indiffed at 1 ☐ Yes 2 No MD Director FAHSTON 10e. Strong 14 Nambocean Drive 10g. Citizen of What Country? 21842 10f. Zip Code U.S.A. 047 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0036 Specify: à 3 Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry should be filad within 7, and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12+2 Benty Bthen Thom 25 BEUTICIAN SALON NIA Alth and Mental Hv. 7 Is mant 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be BREITENBACK MARGAMET KIRBY 19a. Informant's Name/Relationship (Type, Print) 19) Mailing Address (Street and Number or Bural Route Number, City of Lown State Zio Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is eny injury or other tra M. PATRICIA FROMMEYER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 3/29/05 + Burial 2 ☐ Cremation 3 ☐ Removal from State Forest cem `4 Donation 5 Dother (Specify) GARRISON MILLS OWINGS 21. Signature of Funeral Service Licensee 22. Name and Address of Facility - STELLA FUNERAL HOME CHTD HARTIEN Miller 7527 halfero teller BA HE MS 21234 RO. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical as a consequence of): Due to (or plications of overnan encer Examiner P24 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine use as the burial-transit Due to (or as a consequence of): the attending physician Box 68760 Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) \_ P.O. I 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à GVarian CONCER 1 Tyes 2 No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an xitction autopsy performed 21X No 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Yes 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ER/Outpatient 3 DOA this Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred e Hospitel or Attending Pl 24 hours after death. a Funerel Director: After th Certification; 1 Natural 2 Accident 5 Pending investigation 1 Tes 2 No 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To tha Funerel E Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified 0 -00C de 30. Name and address of person who compteted cause of death (Item 23a) (Type, Print) Hospital of Beltimore A. Bohannon, MD SINZI 2. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 2 8 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Obath **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of/Death **Examiner** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Social Security Number Funeral 6. Sex Birthplace (State or Foreign Country) Days 101M 2□ F 240-09-878 Usual Residence of Decedent Director death with the Maryland 10a. State 10b. County 10c. City, Town or Location item 27 la markad other than "natural", or Items 23a or 28a-f show othar traumatic evant. The Medical Exercited in ust by indiffied at 10d. Inside City Limits 1 Pes 2 No Director 10 Y 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4404 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If item 27 Ia marked other than "natural', or Iten any injury or other traumatic evant, the Medical Examina. Once. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: B 3 Widowed 4 Divorced GCK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) Sr. 19a. Informant's Name/Relations ip (Type, Print) [[1] 1000] 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 365 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 5 Pother (Specify) ENTOMBMENT ¹ 4 □ Donation Loudon . NOTE AVENUE. ther ye disease or complications that deused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician on ers /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner sician and burial-transit Due to (or as a consequence of): been signed by the attending physician should be detached for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ZUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 X No 1 Yes 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 👿 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.
To the Funeral Diractor: After 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 150 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EETINDER

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		1 - For Stete Registrar	State of I	Maryland /		artment of F rtificate of		and Mei		iene eg. No.?	005	10	200
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Funeral Director			Sex 7. 1 □ M 2 🙀 F	Age (In yrs. last I	Yrs.	Months Days	Hours		Date of Birth (Month, Day,		Cour		or Foreign
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			for State Registrar	State of Maryla		artment of H			iene g. No. 201	15 10000
	Physici		Decedent's Name (First, Middle, Last)     Paul S. Benr	nett				2. Date of Death Month March 24	n Day V	3. Time of beath 4:00 p M
	/Medic Examin		4a. Facility Name (If not institution, give s Edenwald	treet and number)		4b. City, Town, o	r Location of Death		4c. County of Baltime	
	Funeral Director		5. Social Security Number 215-10-4137 6. Sex Usual Residence of Decedent	M 2□F 7. Age (In yr	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Sept. 29	,1912 N	Birthplace (State or Foreign Country) Maryland
	e Maryland 3a-f show	ctor	10a. State 10b. County  Maryland Baltimore		City, Town or Lo	n				10d. Inside City Limits
	h with th	ai Directo	10e. Street and Number 800 Southerly Road	i #215		10f. Zip Code 21286	5	1	Og. Citizen of Wha	at Country?
000	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.  Is marked to their than *natural*, or Items 23e or 28e-f show is marked other than *natural*, or Items 20e or 28e-f show aumatic event, the Madical Examinational Let natified at	by Funerai	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	2. Was Decedent Ever in Armed Forces?  1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:	'	Was Decedent of H f Yes, specify Cub 1 ☐ Yes 2 ☐ No	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)		American Indian, White, etc. White
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	b d la b	To Be Co	11 17. Father's Name (First, Middle, Last) William Bennett		Super	rvisor	18. Mother's Nam	ne (First, Middle, M	Maiden Surname)	nufacturer
	D = 1 =		19a. Informant's Name/Relationship (Ty) Michael P. Bennetty			ng Address (Street	and Number or Rui	rai Route Number, aneytown		
<u> </u>	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		20a. Method of Disposition  1 X Burial 2 Cremation 3 R  4 Donation 5 Other (Specify)  21. Signature of Poperal Pervix Licenses	emoval from State	Place of Dispo cametery, crar erusaler	sition (Name of natory or other pla T Ev. Ch. 2. Name and Addre	Cem. 3/26	6/05 E	1050	e Maryland York Road
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Division of vital necolus,	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	To Be	25. Was case referred to medical examinar?  1  Yes 2 No H  27. Manner of Death 1 Natural 5 Pending investigation	lospital: 1 ☐ Inpatient 2 28a. Date of Injury (Month, Day Year,	ER/Outpatier 28b. Time o Injury	f 28c. Inju	her: 4 ursing H	ome 5 Reside		(Specify)
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	ne Hospi ne Funer bletely fill	Medical		sician: To the best of my k ner: On the basis of exam and manner stated.						
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2	07		30. Name and address of person who co	MARNIA	tem 23a) (Type,	Print)	P MIL	20 m cs	-1 N 157	24,2005 71607,710 21096
	Sta Regist		31. Date filed (Month, Day, Year) MAR 2 8 2005	32. Registrar's Sig	nature					-

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Year В. Cavin 22 2005 /Medical March 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town or Location of Death **Examiner** St. Agnes Hospital N/A Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 ☐ M 2 🕅 F Months Days Hours Yrs. Director 218-42-1029 58 England Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ont: If item 27 is marked other then "naturel", or Items 23a or 28e-f ehow 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other then "naturel", or Items 23a or 28e-f ehov treumetic event, the Nedical Examinat must be notified at 1. Yes 2 No Director Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3207 Janice Avenue 21227 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ VNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Completed by White Specify: 3 Widowed 4 Divorced . 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 Financial Office Non Profit 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William White Rosa Revuelta ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Importent: If item 27 is eny injury or other tree once. Erin N. Cavin (daughter) 3207 Janice Avenue, Baltimore, MD 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State March 26 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Metro Crematory Inc. 2005 <sup>1</sup> 4 □ Donation 5 □ Other (Specify) Baltimore, Maryland 21. Signati re ol Funeral Service Licen Stallings Funeral Home, P.A. 22. Name and Address of Facility 3111 Mountain Road, Pasadena, MD 21122  $\ensuremath{\operatorname{chid}}$  sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Enysician Hylmonory 0045 /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner anding physician and use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Year 4☐Pregnant at time of death Month Day 5 Other (specify) P.O. 1 ☐ Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ∠ Yes 2 □ No 24a. Was an autopsy performed? 1 Yes 2 🗆 No the Hospitel or Attending Physicien; 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Certification; To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 😾 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Teath 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No within 24 hours after deatl To the Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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State Registrar DHMH 17 Rev 1/2001

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31. Date liled (Month, Day, Year)

St Agnes Healthcare

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ner	4a. Facility	/ Name (/	f not institutio	on, give str	reet and nu	imber)			4b. City,	Town, or	r Location	of Death			tc. County		
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Registrar DHMH 17 Rev 1/2001

		For State Registrar	State of Ma		/ Depa	rtment of F	lealth and	Mental Hy	•	105 1000
					Cer	tificate of	Death		Reg. No.	101 1018
Physici	an	1. Decedent's Name (First, Middle, a		-				2. Date of De Month	Day	Year 3. Time of Death
/Medi	al		ARRING	701	V ,	4h Oh T		MARCH		2005 6:50 PN
Examir	er	4a. Facility Name (If not institution, g		0 1	00.00	4b. City, Town, o			4c. County	of Death
Funeral		5. Social Security Number 6	Sex 7. Ag	e (In yrs. lasi	CEVIEN t birthday)	If Under 1 Year	TIMOI If Under 24 H	rs. 8. Date of Bir	th	9. Birthplace (State or Foreign
Director		214-88-9114	1 □ M 27 F	40	Yrs.	Months Days	Hours M	June 4	v. Year)	9. Birthplace (State or Foreig Country)  MD
P.		Usual Residence of Decedent		1					,	
arylau shov	-	10a. State 10b. County		10c. City, T	own or Loc	cation				10d. Inside City Limits 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
he M.	ecto	MD			Balt	imore				
with t	吉	10e. Street and Number				10f. Zip Code			10g. Citizen of \	
72 hours after death with the Maryland naturel', or Items 23e or 28e-f show dical Examinations to rediffed at	Funeral Director	2935 Yorkway Dr:	ive 12. Was Decedent	Ever in U.S.	13 V	21222		(Specify Yes or No	US 14 Bac	SA ce - American Indian,
fter d	표	1 ☐ Never Married 2 ☐ Married	Armed Forces?  1 ☐ Yes 2 🕅		If	Yes, specify Cub	an, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	Blac	ck, White, etc.
ol', o	by	3 ☐ Widowed 4 🎇 Divorced	If Yes, Give Year or Dates:		1	☐ Yes 2🌠 No	Specify:		Specify	y: White
72 ho	Completed	15. Decedent's (Specify only highest of	Education	1	16a. Deced	ent's Usual Occup	ation	vorkina	16b. Kind of B	usiness/Industry
within ene. then "	npl	Elementary/Secondary (0-12)	College (1-4or 5	i+)	life. D	kind of work done OO NOT use retire	d)			
e filed within at Hygiene. other then		12	-41		Ho	usewife	40 14-4			Home
tbe fi	Be	17. Father's Name (First, Middle, La						lame (First, Middle,	Maiden Suman	16)
d 2 should be filed within 72 hours aft this and Mental Hygiens 17 is marked other then "naturel; or treumatic event, the Medical Exam	L C	Vincent J. Merlo  19a. Informant's Name/Relationship			10h Mailin	Address (Christ		Lennert Rural Route Number	Ch T.	State 7'- O- del
d 2 sho th and 7 is m treum										
		Vincent J. Merlo 20a. Method of Disposition	Sr. Fat	120b. Plac	e of Dispos	ition (Name of		Reisters Date	20c. Location -	D 21136 City or Town, State
Pages nent of I ant: If its ury or o		1 XBurial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Spe				atory or other pla	· 1	/00 /05		
permit. Pages 1 ar Department of Hea Important: If itsm any injury or other		21. Signature of Funeral Service Lic		WOOd		Cemetery Name and Addre		<sup>7</sup> 29/05		imore, MD stown Road
permi Depa Impo any ir		B. B.	of time							MD 21136
		a. P. t1. Enter the disease, or co	mplications that caused	I the death. I						Approximate
Physician		shock, or heart failure. List on Immediate Cause (Final	ny one cause on each iir	1e.		curre	000			Interval Between Onset and Death
/Medical		disease or condition resulting in death)	aDue to (or as	a consequen	nce of):	EXACE	KISHI	OIV		
Examiner			PNEU							
n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequen	nce of):					
acuter nd trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c							
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that the death certificate ed by the attending physi detached for use as the	/Me	IF FEMALE:	23c. If yes, outcome	of pregnance						
atten for us	sian	23b. Was decedent pregnant in the past 12 months?	1☐Live birth 4☐Pregnant at	2 Fetal de	ath 3	Ectopic pregnancy Other (specify)	1			te of delivery onth Day Year
the d	isic	1  Yes 2  No 9  Unknown	9 Unknown	timo or death	3	Other (specify)				
The law requires that the ten seem signed by the bas been signed by the bage 2 should be detached.	Completed by Physician/Med	Part II. Other significant conditions	contributing to death b	ut not resultir	ng in the un	derlying cause giv	en in Part I.	23e. Did to	obacco use cont	ribute to the cause of death?
quires n sign	d b	ASTHMA, OBS	MENCIIVE	SLE	EP	APNEA		120	res 2 □ No	3 Probably 4 Unknown
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The lav	mo	DEPENDENC				1-1-01		autop	rmoged?	prior to completion of cause of death?
ilcien: Th certificate rector, pag	Be C	25. Was case referred to medical	4				26. Place of D	1 ☐ Yes leath (Check only o		1 ☐ Yes 2 ☐ No
Physicien: this certific ral director,	To B	examiner? 1 ☐ Yes 2 📆 No	Hospital: 1 Inpatie	nt 2 ER	VOutpatient	3□ DOA Oth	00	Home 5 Resid		er (Specify)
iding Phys th. After this funeral di		27. Manner of Death  1 Matural 5 ☐ Pending	28a. Date of Injur	ry 28	Bb. Time of Injury	28c. Injur Wor	y at		now injury occurr	
or Attending after death. Director: After d in by the funer	atlc	2 ☐ Accident investigat	on		,,		Yes 2 □ No			
or Att ter de irect	Certification;	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ury - At home c. (Specify)	e, farm, stre	et, factory, office		28f. Location (S City or Tox		er or Rural Route Number,
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To the Hospital or Attendia within 24 hours atter death. To the Eunerel Director: A completely filled in by the fu	Med	une)	and manner sta	itea.						d (Month, Day, Year)
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Registi		MAR 28	2005 32 degistra	es Si	6.00					

		1. Decedent's Name (First, Middle,	Last)					Date of Deat		W 33	3. Time of Death
Physicia		Beverly A. Cox					N	Month 1ARCH	23 20	005	5:30A
/Medic		4a. Fecility Name (If not institution,	give street and number)		4b. City, Town, o	or Location of	of Death		4c. County		
		3826 Perryhurst	Place		Perry	Hall			Bal	timor	'e
Funeral		5. Social Security Number 6	5. Sex 7. Ag	ge (In yrs. last birthda	Months Days		24 Hrs. 8. [ Min.	Date of Birth Month, Day,	1938	9. Birthp	lace (State or Fore
Director		213-36-8291	ILIM ZAJF	66 Yrs.				6/15/ <del>1</del>			yland
M I	}	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location					1	0d. Inside City Lim
Is how	ō	Maryland Baltim	ore	Po	erry Hall/	/Balti	more C	ountv			1 □ Yes 2 <b>X</b>
28a-	rect	10e. Street and Number			10f. Zip Code				0g. Citizen of V	What Coun	itry?
ene. than "natural", or items 23a or 28a-1 show it Medical Examination at the natified at	Funeral Director	2026 Downships	- Dlago		2123	6			U.S.A.		
ms 2	Jera	3826 Perryhurst 11. Marital Status	12. Was Decedent		3. Was Decedent of H	Hispanic Ori	gin? (Specify	Yes or No-	14. Rac	e - Americ	
or ite	Ξ	1 ☐ Never Married 2 X Marrie	Armed Forces? d 1 ☐ Yes 2 💢 If Yes, Give	No	If Yes, specify Cuba 1 ☐ Yes 2X No			n, etc.)		ck, White,	etc.
I B	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		TI Tes ZAINO	Specify.			Specify	Whi	te
"natu	Completed	15. Decedent's (Specify only highest	Education grade completed)	(Gi	cedent's Usual Occupive kind of work done	during most	t of working	1	16b. Kind of Bu	usiness/Ind	dustry
han han	m	Elementary/Secondary (0-12)	College (1-4or	5+)	e. DO NOT use retired	d)					
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ed of	Be	STEIN	331)							10)	
h and Mental Hygiene. 7 Is marked other than " traumatic evant, tra Me.	၉	John Stern  19a. Informant's Name/Relationshi	n (Tyne Print)	19h Ma	ailing Address (Street		en Bins			State Zio	Code
trau					5.00						,
it of Health and Mental Hygiene. If itam 27 Is marked other than "natural", or items 23a or 28a-1 show or othar traumatic evant, if a Medical Examinations to nother or		Robert L. Cox, S 20a. Method of Disposition	or.	20b. Place of Dis	Perryhur		Date		20c. Location -		
nent of I int: If its iry or o		1 Burial 2 Cremation 3	Removal from State		rematory or other place	1	2/26/2	005 0-			
	- 1	<ul><li>4 □ Donation 5 □ Other (Special Service Li</li><li>21. Signature of Funeral Service Li</li></ul>		Druid R	idge Cemet					e,Mar	ryland
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		23a. Part1. Enter the disease, or or	racoro								
			omplications that caused	the death. Do not e		· · · · · · · · · · · · · · · · · · ·					Approximate
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	For State Registrar	te of Maryland / Department of Health a  Certificate of Death	nd Mental Hygien	2005 10300
Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)  4a. Facility Name (If not institution, give street a	Cobbs	2. Date of Death Month D	3. Time of Death
Funeral Director	5. Social Security Number  6. Sex  228-58-5783  1 M 2  Usual Residence of Decedent	1. Age (In yrs. last birthday) If Under 1 Year If Under 2	50	NA
Raryland Ba-f show Illied at	10a. State 10b. County	10c. City, Town or Location BaltiMore		10d. Inside City Limits 1 Xes 2 □ No
aryland 21215-0036 should be filled within 72 hours after death with the Maryland nd Mental Hygiene. marked other than "natural; or items 23s or 28s-f show unsetic avant, it a Madical Examiter roust be notified at To Be Completed by Funeral Director	Am	s Decedent Ever in U.S. led Forces?  Yes 2 No es, Give ar or Dates:  10f. Zip Code  11g. Zip Code  11g. Zip Code  11g. Zip Code  11g. Zip Code  11g. Zip Code  11g. Zip Code  11g. Zip Code  11g. Zip Code  11g. Zip Code  11g. Zip Code  11g. Zip Code  11g. Zip Code  11g. Zip Code  11g. Zip Code  11g. Zip Code	n? (Specify Yes or No-	14. Race - American Indian, Black, White, etc.
Maryland 21215-0036 nd 2 should be filed within 72 hours all the and Mental Hygiene.  27 is marked other than "natural; or retaumetic event, the Marical Exami	15. Decedent's Education (Specify only highest grade comp  Elementary/Secondary (0-12)  Col  17. Father's Name (First, Middle, Last)	lege (1-4or 5+)  Nife. DO NOT use retired)	of working	rivate
iore, Maryland 212 ges 1 and 2 should be filed with t of Health and Mental Hygiene if Itam 27 is marked other that or other traumetic avent, the incomplete of the complete of	19a. Informant's Name/Relationship (Type, Prin	UNK Pri	s Name (First, Middle, Maider  NCLTC Sr  or Rural Route Number, City	nith
than than	JOSEPH ROYAL  20a. Method of Disposition  1	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. L	ocation - City or Town, State
Baltimor Permit, Pages Department of Important: if the any injury or o	'4 □ Onation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	22. Name and Address of Facility 30.5.e.p.h.2. Ku S 22.2.W. NOTINA	124/2005 ) cuneral Home ve Baltimore	undalk, Md.
Physician /Medical	Immediate Cause (Final disease or condition resulting in death)	that caused the death. Do not enter the mode of dying, such as con each line.	ardiac or respiratory arrest.	Approximate Interval Between Onset and Death
3760, step be executed stysician and he burial-transit lcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	ue to (or as a consequence of):  ue to (or as a consequence of):  ue to (or as a consequence of):		i year
O. Box 6 he death certific the attending the attending sched for use as	in the past 12 months?	as, outcome of pregnancy Live birth 2   Fetal death 3   Ectopic pregnancy Pregnant at time of death 5   Other (specify)   Unknown		23d. Date of delivery Month Day Year
Records, P. P. P. P. P. P. P. P. P. P. P. P. P.		g to death but not resulting in the underlying cause given in Part I.		use contribute to the cause of death?
of Vital Records, P. Physician: The law requires that this certificate has been signed by all director, page 2 should be detailed. To Be Completed by Ph	<i></i>		24a. Was an autopsy performen? 1 Yes 2	24b. Were autopsy findings available prior to completion of cause of death?  1  Yes 2 No
of Viit; of Viiting this certification of this certification of this certification of the control of the contro	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No  27. Manner of Death  28a.	1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nurs	ng Home 5  Residence 28d. Describe how inju	6 Dother (Specify) Hospies
Division of tall or Attending P is after death.  al Director: After ed in by the funer:  Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e.	Date of Injury (Month, Day Year)  Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		nd Number or Rural Route Number.
D In the Hospital of in 24 hours at the Funaral Diplotely filled in edical Cer	29a. Certifier 1 Certifying Physician: (Check only 2 Medical Examiner: On	To the best of my knowledge, death occurred at the time, date and put the basis of examination and/or investigation, in my opinion, death imanner stated.	place, and due to the cause(s)	and manner as stated
To the within To the comple	29b. Signature and title of certifier  Policy June 1. P.D.	29c. License number Docowns		te signed (Month, Day, Year)
5	30. Name and address of person who completed	d cause of death (Item 23a) (Type, Print)  8824 W: nando Read . Randall)	town, MD. 2	833
State Registrar	31. Date filed (Month, Day, Year)  MAR 2 8	882 k Winands Road. Randalls 32. Registrar's minature		

			A FOI	epartment of Health and Me Certificate of Death	ental Hygie	,	
	Physici		Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
,	/Medic Examin		Mary Conway 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	March 19	2005 4c. County of Dea	12:10p
			Crofton Convalescent & Rehab.	Crofton		Anne Arı	
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 TF 7. Age (In yrs. last birth)	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Bir	thplace (State or Foreign
	σ		Usual Residence of Decedent		arch 1	1917 Ma	
	arylar show	ž	10a. State 10b. County 10c. City, Town of	or Location			10d. Inside City Limits
	the M	Directo	Varyland Anne Arundel Odento  10e. Street and Number	10f. Zip Code	10a.	Citizen of What C	1
	h with	ID I	646 Old Waugh Chapel Rd.	21113		JSA	,
	ame 2	Funeral		13. Was Decedent of Hispanic Origin? (Specifi Yes, specify Cuban, Mexican, Puerto R		14. Race - Am	
36	filed within 72 hours after death with the Maryland Hygione. Khisr than "naturelt, or iteme 23a or 28a-f show ant, Ina Medical Execution roust be rediffed at	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒No Specify:	,	Specify: B	
ş	2 hour	ted b	15. Decedent's Education 16a. D	ecedent's Usual Occupation	16b	. Kind of Business	/Industry
215	thin 7.	Completed	(Specify only highest grade completed)  [King (Specify only highest grade completed)  [King (Specify only highest grade completed)  [King (Specify only highest grade completed)	Give kind of work done during most of working ife. DO NOT use retired)	9		
121	iled wi tygien her th	Con	7th 0	Housewife 18. Mother's Name	/First Middle Mai	None	
Maryland 21215-0036	bed be	To Be	Edward Hall		Griffir		
ary	s 1 and 2 should be f Heelth and Mental Itam 27 is marked o other treumatic eve	-		Mailing Address (Street and Number or Rural			Zip Code)
Ž	12 g g			Cadbury Dr. Oder	-		
ltimore,	Pages 1 nent of Ho int: if iter iry or oth		cemetery,	hisposition (Name of crematory or other place)  Crest Cemetery 3/2		Location · City or	
<u>=</u>			* 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	22. Name and Address of Facility	24/03 F	nnapoli	.s, Ma.
Ba	permit. Departi Import any inf		Janu H. Room MOOY83	Wm. Reese & Sons 821 West St. Ann	Mortua	ry, P.A	101
			23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each like.			Mu. Z	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	2 Arrettoma			Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of)				
L,		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	:			
	cuted nd transit	Examiner	that initiated events C.				
90,	ate be executed hysician and the burial-transit		resulting in death) Last Due to (or as a consequence of)	:			
09/89	the the	dicai	d				
Box	death certifica e attending ph id for use as th	n/Me	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death	205		23d. Date of de	livery
O. B	0 0 0	Physician/Med	1 Yes 2 1000 4 Pregnant at time of death	3 □Ectopic pregnancy 5 □ Other (specify)		Month	Day Year
۵.	res that the de signed by the a be detached f	Phy	9 ☐ Unknown / 9☐ Unknown / Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I.	23e. Did tobaco	o use contribute to	the cause of death?
Vital Records,	The law requires that the te has been signed by th bage 2 should be detache	d by	Failure to thrine		1 ☐ Yes	2 No 3 P	obably 4 Onknown
<u>0</u>	aw require s been sig 2 should b	Completed			24a. Was an	24b. Were a	utopsy findings available
m m		mo			autopsy performed 1 Yes 2	?/ death?	completion of cause of 2 □ No
/ita	Physicien: Th rthis certificete ral director, pag	Be	25. Was case referred to medical examiner?	26. Place of Death			
ō	Phys this aldii	. To	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outp  27. Manger of Death 28a. Date of Injury 28b. Tin		e 5 Residence		cify)
lon	nding th. : After s fune	ition	1 √ Natural 5 □ Pending (Month, Day Year) Inju		od. Dodonbo now ii	ijury occurred	
Division of	or Attanding P after death. I Director: After t d in by the funera	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury · At home, farm building, etc. (Specify)	i, street, factory, office	8f. Location (Street City or Town, St	and Number or R	ural Route Number,
	oitet oi urs aft rel Di						
	To the Hospitel or Attanding within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical	29a. Certifier Check only one) Check only one) Check only one)	leath occurred at the time, date and place, ar or investigation, in my opinion, death occurred	nd due to the cause d at the time, date	e(s) and manner as and place, and due	s stated. e to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Mont	h, Day, Year)
				DONOZ8	3	-23-05	•
			30. Name and address of person who completed cause of death (Item 23a) (Ty	ype, Print)			
	Sta	te	31. Date filed (Month, Day, Year)  32. Begistrar's Signature	gely Ave. Ste. 231,	Annapa	115,mo	21401
	Registr		MAR 2 8 2005	light.			

			State of Maryland / Department of Health and  1- For State Registrar  Certificate of Death	Mental Hy	giene 0	05 10390
	Physici /Medic	al	1. Decedent's Name (First, Middle, Last)  Jane Z. Davenfort	2. Date of De Month	Day	Year 2005 15.2 CM
	Examin Funeral	er	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Dea  3c. I times =  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  If Under 1 Year   If Under 24 Hrs.  Months   Days   Hours   Min	8. Date of Bir	4c. County	9. Birthplace (State or Foreign
	Director		215-24-9022       1□ M 25 F       93       Yrs.       Months Days Hours Min         Usual Residence of Decedent         10a. State       10b. County       10c. City, Town or Location	2-20-	1922	North Carolina  10d. Inside City Limits
	ith the Mary or 28e-f sh	Director	Md N/A Baltimore  106. Street and Number 101. Zip Code		10g. Citizen of W	1522Yes 2 □ No  What Country?
ď	ified within 72 hours after death with the Maryland Hygiene. Hygiene. Then "natural; or Items 23e or 28e-f show after than "natural; or Items 23e or 28e-f show ant, Ire Madical Examiner must be notified at	Funeral Director	2 4 0 4 E/S i no re Ave 2/2/4  11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married  1 Yes 2 2 No 4 No 2 No 2 No 2 No 2 No 2 No 2	Specify Yes or No to Rican, etc.)		e - American Indian, k, White, etc.
Raltimore Maryland 21215-0036	in 72 hours n "natural",	Completed by	3.50 Widowed 4 □ Divorced	rking	Specify:	17/0001
210 pue	partition of a war yearly sail of a lack manner and a permit. Pages 1 and 2 should be filled within Department of Health and Mental Hygiene. Importent: If item 27 is marked other than any injury or other treumatic event, I.e. Monce.	Be	17. Father's Name (First, Middle, Last)  18. Mother's Na	de	, Maiden Sumame	rament
Month of the state	o, Ividi y idili.	٦	19a. Informant's Name/Relationship Type, Print)  Dean Handy daughter  19b. Mailing Address (Street and Number for R 2404 Elsin Ore de	1	er, City or Town, S	State, Zip Code)
#i# oro	it. Pages 1: ritment of He ordent: If iten njury or oth		20a. Method of Disposition  1 \$\Burial 2 \subseteq Cremation 3 \subseteq Removal from State  4 \$\subseteq Donation 5 \subseteq Other (Specify)  21. Signature of Funeral/Service Licensee  22. Name and Address of Partitive  22. Name and Address of Partitive	Date 2015	East Past	City or Town, State
ä	permit. Departit Importe any inju	6 .	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line.	St. Ba	Stringle, rrest,	Approximate Interval Between
	Fnysician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Runtvice Iliac Ameuriyan  Due to (or as a consequence of):			Onset and Death  3diys
K	ocuted nd transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Filter Underlying Cause (Disease or injury that initiated events c.			
	flicate be executed physician and ss the burial-transit	icai	Due to (or as a consequence of):  d.			
2 2 C	ath cert	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)		23d. Date Mon	e of delivery hth Day Year
	v requires that the de been signed by the a should be detached f	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		obacco use contri Yes 2□No	ibute to the cause of death? 3 Probably 4 Qunknown
port, Je	sicien: The law requirection: The law requirection page 2 should	e Completed	25. Was case referred to medical 26. Place of De	1 ☐ Yes	2 No 1	Vere autopsy findings available rior to completion of cause of leath?
< to	Physical distribution	To B	28. Place of De Service Place Of De Service Place Of De Service Place Of De Service Place Of De Service Place Of De Service Place Of De Service Place Of De Service Place Of De Service Place Of De Service Place Of De Service Place Of De Service Place Place Place Of De Service Place Pl			
Dave	To the Hospital or Attending Physicien: The law within 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Certification;	2 Accident investigation 2 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location ( City or To	Street and Numbe wn, State)	er or Rural Route Number,
	the Hospital in 24 hours the Funerel ipletely filled	edical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and occurred at the time, date and death occurred at the time, date and death occurred at the time, date and death occurred at the time, date and death occurred at the time, date and death occurred at the time, date and death occurred at the time, date and death occurred at the time, date and death occurred at the time, date and death occurred at the time, date and death occurred at the time, date and death occurred at the time, date and death occurred at the time, date and death occurred at the time, date and death occurred at the time, date and death occurred at the time, date and death occurred at the time, date and death occurred at the time, date and death occurred at the time, date and death occurred	e, and due to the urred at the time,	cause(s) and mar date and place, a	nner as stated. and due to the cause(s)
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	Registr		31. Date filed (Month, Day, Year)  MAR 2 8 2005  32. Registrar's Signature			

		110000	State of Ma	ırylar	id / Depa	artmer	nt of H	lealth and	d Mer	ntal Hy	giene	Logibio.	
		1 - For State Registrar		,				Death		-	Reg. No.	2000	10391
		1. Decedent's Name (First, Middle, Las	t)		-					Date of De Month	ath Day	Year	3. Time of Death
Physici /Medic		Betty M Dilla	rd							larch			- 6:37 PM
Examin		4a. Facility Name (If not institution, give	street and number)					Location of De			1	County of Dea	
		Harford Memer	ial Hosp	ita	1			De Gra	,			Harfor	
Funeral		5. Social Security Number 6. S 6. S 1	ox 7. Age □M syElF	61	last birthday) Yrs.	Months	Days		fin.	Date of Bir (Month, Da	y, Year)	9. 8	rthplace (State or Foreign ountry)
Director		Usual Residence of Decedent	71	<u> </u>		1.				ec.	١,	1943 M	laryland
ylanc		10a. State 10b. County MD Harfor		10c. Ci	ty, Town or Lo		_						10d. Inside City Limits
ith the Marylar or 28e-1 show	cto	MD Harfor	. u		Havre	De	Gra	ce					1 □ Yes 2 📉 No
is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23e or 28e-f show other traumatic event, the Madical Examinat must be notilied at	Funeral Director	10e. Street and Number	Drive			10f. Z	p Code	078			10g. Citi USA	zen of What C	ountry?
s 23e	rai	2104 Williams	12. Was Decedent 8	Tuncia II	C 142	Man Dani			1 /Consider			14. Race - Am	nican Indian
ltem Item	'n.	11. Marital Status 1 ☐ Never Married ————————————————————————————————————	Armed Forces?		.5.	If Yes, sp	ecify Cuba	ispanic Origin? In, Mexican, Pu	uerto Rica	an, etc.)		Black, Whi	
urs af	by	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ N If Yes, Give X Year or Dates:			1 🗆 Yes	a√ No	Specify:				Specify: Wh	nite
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e. Ben "r	npie	Elementary/Secondary (0-12)	College (1-4or 5	+)	life.	DO NOT	ise retired	i)	WOIKING		0.	vn Hom	
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2 should be filed within and Mental Hygiene. Is marked other then aumatic event. The Mental Hygiene.	Be	17. Father's Name (First, Middle, Last)  Leonard Gries	z t					18. Mother's I				Sumame)	
y lould a Mer narke	2	19a. Informant's Name/Relationship			10h 14aili	a a Addes	o (Ctrant	and Number or				Tour State	Zin Codel
d 2 st d 2 st th and 7 is r traun		Willie Dillard	** *	E	Transaction and								
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ages ont of t: If It		1  Burial 2  Cremation 3  C 4  Donation 5  Other (Specific		i	cemetery, cre	-	other plac	03/	/26/	05	Bali	timore	. MD
nit. Partme		21. Signature of Funeral Service Licer		I HC	olly H		nd Addres						
permit. Pages 1 and 2 Department of Health a important: If Itam 27 is any injury or other tra		PR Term	1 / 200	XV.				Avenue					meofEssex
El Sus 1		23a. Part1. Enter the disease, or conshock, or heart failure. List	cations that caused	the dear	o not en	ter the mo	de of dyin	g, such as care	diac or re	spiratory a	rrest,	, MD Z	Approximate Interval Between
Physician		Immediate Cause (Final	one cause on each lin										Onset and Death
/Medical		disease or condition resulting in death)	a. Due to (or as		quence of):	4.1	icy	nocri	6	2			30 190013
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Physicien: The law requires that the death certificate this certificate has been signed by the attending physial director, page 2 should be detached for use as the	/Me	IF FEMALE:	23c. If yes, outcome	of pregn	ancy							23d. Date of de	aliveny
atter	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1☐Live birth 4☐Pregnant at			Ectopic   Other (s	oregnancy pecify)	,			-   -	Month	Day Year
that the de ed by the detached	nysi	9 Unknown	9□ Unknown										
lires that signed b	by PI	Part II, Other significant conditions of	ontributing to death be	ut not res	sulting in the u	ınderlying	cause give	en in Part I.		23e. Did t	obacco u	se contribute t	to the cause of death?
v requires been sign should be									_	1 🗆 '	Yes 2[	□No 3□P	robably 4 Onknown
aw requisite to the second sec	plet									24a. Was		24b. Were a	utopsy findings available completion of cause of
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ysicien: Th is certificate director, pag	Bec	25. Was case referred to medical examiner?						26. Place of I	Death (C				
Physic this ce al dire	2	1 Yes 2 No	Hospital:		ER/Outpatie			4 LI Nursin	g Home	5 🗀 Resi	dence 6	3 □Other (Spe	ecify)
ine in enu	ation;	27. Manner of Death  1. □Natural 5 □ Pending	28a. Date of Injur (Month, Day	Year)	28b. Time o Injury		28c. Injun Worl		28d	Describe	now injur	y occurred	
teath feath tor: /	cati	2 Accident investigation 3 Suicide 6 Could not be			L.,	M		Yes 2 □No	204	Lauretina (	0	-( * (	
or Att	Certific	4 Homicide determined	28e. Place of Inju- building, etc	. (Speci	ome, tarm, st fy)	reet, facto	ry, office		281.	City or To			lural Route Number,
pital Durs a leral i		29a. Certifier 17 Legrifying Ph	ysician: To the best of	of my kn	nwladna daat	h occurre	d at the tin	ne date and ol	are and	due to the	causo(s)	and manner a	s stated
24 hc 24 hc Fun etely	Medical		niner: On the basis of and manner sta	examina									
To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Me	29b. Signature and title of certifier				25	9c. License	e number			29d. Dat	e signed (Mon	th, Day, Year)
- > - 0		1 tunt In	~				4 50	7222	2		Nac	4 23	2005
		30. Name and address of person who	completed cause of de	eath (Ite	m 23a) (Type.	Print)							
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Sta	ate	31. Date filett/Month, Ray Year)	32. Registra	ar's Sign	ature	y .		. , .				,	
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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Randell Duncan 1- State Unpend Item 23a,27,28a-f per me (342,4-8005) tas 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Rande11 Duncan 2005 7:20A. MARCH /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 4001 SUITLAND ROAD PRINCE GEORGES SUITLAND 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Aug 9,1982 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours 1 ☐ M 2 ☐ F 578-11-8885 22 Washington DC Director Yrs. Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ehow Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Heatth and Mental Hygiene. and tem 'neturel', or flems 23a or 28a-1 ehov ant: If Item 27 Is marked other than "naturel", or flems 23a or 28a-1 ehov ury or other traumatic event, I're M. M. Jical Examinat must be notified at 1∏Yes 2∏No Maryland | Prince George Bowie Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2219 Prince of Wales Court 20716 United States 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status e filed within 72 hours after at Hygiene.

other than "naturel", or ite 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Black þ Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business/Industry e kind of work done di DO NOT use retired) (Specify only highest grade completed) National Science Elementary/Secondary (0-12) College (1-4or 5+) Twelve Two Automation Clerk Foundation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Lorando Duncan Sr Carrie Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2219 Prince of Wales Court, Bowie, MD 20716 Carrie Brown-Duncan/Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State permit. Page Depertment of Important: If any injury or once. Riverdale Crematory | March 21,2005 Riverdale, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service L 22. Name and Address of Facility Robert G. Mason Funeral Home 1661 Good Hope Rd SE, Washington DC 20020 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Sharp Force And Thermal Injuries /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of): certificate be executed burial-transit that initiated events and resulting in death) Last Due to (or as a consequence of): physician s the burial Division of Vital Records. P.O. Box 68760. Physician/Medical as ding IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? atter 3 Ectopic pregnancy ō Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signe t be d þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1X Yes 2 No Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\chi$  Other (Specify) SCENE 1

Yes 2

No 2 ER/Outpatient 3 DOA 28a. Date of Injury **Found**Pay Year) 28b. Time of Subject Cut Self And Set 27 Manner of Death Certification: Found 7:12 1 Natural 5 Pending 1 ☐ Yes 2 🙀 No death. investigation Himself On Fire 2 Aucident after death 3-15-05 6 ☐ Could not be Suicide Homicide Location (Street and Number of Rural Route Number, City or Town, State 4001 Suitland Road, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Suitland, within 24 hours a To the Funeral C Scene 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME (mus MARCH 16,2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RUBIO , MD 111 Penn Street Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Degistrar's Signature State MAR 2 8 2005 Registrar

Traper, Wallace

Baltimore, Maryland 21215-0036

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Month



29c. License number

58303

ST Routhing

29d. Date signed (Month, Day, Year)

morch 25 2005

21204.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 1:49 WALTER R DORRIER MARCH 24 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE N/A BALTIMORE MEDICAL CENTER NA If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex Birthplace (State or Foreign Country) Funeral Days Hours 1**⊠**M 2□F 78 219-20-4611 Director Sept. 8,1926 Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 7 is markad other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exarts at most ke notified at Md. Baltimore Edamere 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7337 Waldman Ave. 21219 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after vent of Health and Mental Hygiene. nt: if item 27 is marked other then "natural", or iter 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: à 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Pipe Fitter Steel 8 yrs.

17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) H. Frank Dorrier Avandene Hoffman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7337 Waldman Ave. Balto. Md. 21219 Vicky Dorrier othar t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition March 25 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State permit. Page Department of Important: if any injury or injury or Bayview Crematory Baltimore 2005 \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Connelly Funeral Home Of Dundalk
7110 Sollers Point Rd. 21222 23a. Part1. Enter the disease, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician PNEUMONIA ASPIRATION 14 DYAZ /Medical Due to (or as a consequence of): **Examiner** 6 MONTHS DYSPHAGIA Sequentially list conditions, if any, leading to immediate cause. Energy that indicate over the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of) the attending physician hed for use as the buria Box 68760 99 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year detached for in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) ☐Yes 2☐No P.O. 9☐ Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed Division of Vital Records, þ pe CORDNARY ARTERY DISEASE 1 Yes 2 No 3 No Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 1 Yes 2 No 1 Yes 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 

Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 No P this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death To the Hospital or Attanding I within 24 hours after death.
To the Funsral Director: After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide f Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier P15877 MARCH 24 2005 O 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE MD 10 N. GREENE ST., 21201 JEFFREY B ALPERT MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar AMEND ITEM #12 PER FH G842 49 Stift Grate Perific AMEND ITEM #12 PER FH G842 49 Stift G842 49 St Reg. No. < 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day OAM **Physician** DUNI 2025 MARK 2 JOHN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Republication Extended N/A Year | If Under 24 Hrs. Birthplace (State or Foreign Country) If Under 1 8. Date of Birth (Month, Day, Year) OCT. 24, 19 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □XM 2 □ F 81 Vrs 1923 PA. Director 190-18-3969 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10b. County 10a. State 10c. City, Town or Location or items 23e or 28a-f show pluer must be notified at 1 ☐ Yes 2 ☑ No COLGATE Director MD. BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Importent: If tiem 27 is marked other than "... any njury or other trearment." 7830 EASTDALE ROAD UNITED STATES 21224 Funeral 12. Was Decedent Ever in U.S. Armed Forces? XXYes 2 10 If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1□ Yes 2□No Specify: Specify: WHITE Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4 CLERK BETHLEHEM STEEL 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ANNA KARLAK JOHN DUNI 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7830 EASTDALE RD., BALTIMORE, MARYLAND 21224 MARY DUNI/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 1 4 ☐ Donation 5 ☐ Other (Specify) SACRED HEART OF JESUS 3/29/05 BALTIMORE, MARYLAND 21. Sixual re of Funeral Service Licensee. 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVE., BALTIMORE, MARYLAND 21224 23a. Part1. Exper the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Dementia Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit attending physician and Due to (or as a consequence of): P.O. Box 68760, Be Completed by Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 □ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 2 No DM Typel
25. Was case referred to media 2 1 Tyes fo the Hospital or Attending Physicien: director, to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification; To funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1-Natural 2 Accident 5 Pending 1 Yes 2 🗆 No within 24 hours after death. To the Funeral Director: A investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier XIANGRONG MO M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 3900

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31. Date filed (Month, Day, Year)

Bonlevan

Registrar's Signature

Raven

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month O 3 **Physician** Year 20 10 CHARLOTTE DUBIN 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SLADE AVENUE APT. #701 BALTIMORE BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth MAR. 9,1931 Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 ☐ M 2 🙀 F 74 Yrs. MD 216-20-1542 **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location ahow 10d. Inside City Limits other traumatic avant. The Medical Eraniner must be notified at 1 ☐ Yes 2 🛛 No Be Completed by Funeral Director MD BALTIMORE BALTIMORE 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō or items 23a 7 SLADE AVENUE APT. #701 21208 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: WHITE Specify 3 X Widowed 4 □ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) al Hygiene. College (1-4or 5+) **HOMEMAKER** OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) h and Mental h SINGER LEVY MORRIS ROSE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a: If itam 27 is MARC DUBIN / SON 8613 STEVENSON ROAD - STEVENSON, MD 21153 20b. Place of Disposition (Name of cemetery, crematory or other place ACHIM) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State ò tment tant: If 4 ☐ Donation — 5 ☐ Other (Specify) AHAVAS SHALOM (AGUDAS 03/25/2005 injury ROSEDALE, MD permit.
Departn
Imports
any inju 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Toler 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sensis 2 wielc '/Medical Due to (or as a consequence of): **Examiner** moltiple Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 \( \subseteq \text{Yes} \quad 2 \subseteq \text{No} \) Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 None 1 ☐ Yes → No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? this certificate has 2□ No 1 Yes 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 2 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; After or Attanding 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Diractor: in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral C 29a. Certifier 🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) O

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAR 2 8 2005

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gistrar's Signature

			For Stata Registrar	State of M	aryland / Depa <i>Cei</i>	artment of H			ene a. No. 2005	10307	
	Physici	an	1. Decedent's Name (First, Middle, La		JACK	DANSIC	VED	2. Date of Death Month MARCH 22		3. Time of Death 11:45 P M	
	/Medic Examir	al	RAYFIELD  4a. Facility Name (If not institution, giv			4b. City, Town, or			4c. County of Death	.1	
			COPPER RIDGE NU 5. Social Security Number 6. S		ge (In yrs. last birthday)	If Under 1 Year	SYKESV I		9. Birth	CARROLL place (State or Foreign	
	Funeral Director		218-12-2217	1 X M 2□F	78 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, ) OCT.19,	(ear) 1926	MD	
	yland		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits	
	ith the Marylan or 28a-f show	Funerai Director		TIMORE	BALT	IMORE 10f. Zip Code		10	g. Citizen of What Cou	1 ☐ Yes 2 No	
	h with t	ai Dir	10e. Street and Number  11 SLADE AVENUE	#415	21208	10	g. Citizen of what Cou	USA			
	er deat	uner	11, Marital Status	12. Was Decedent	spanic Origin? (S n, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ameri Black, White,				
036	72 hours after death with the Maryland natural', or Items 23a or 28a-f show dical Exactives fourt be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 X Yes 2 ☐ If Yes, Give Year or Dates:	No	1 ☐ Yes 2 💢 No	Specify:		Specify:	WHITE	
21215-0036	in 72 ho "natur	Completed	15. Decedent's E (Specify only highest gra	ade completed)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	luring most of wor	rking	6b. Kind of Business/Ir	dustry	
	filed within Hygiene. Ither than "	Comp	Elementary/Secondary (0-12) College (1-4or 5+)  OWNER  AUTO BODY R								
Maryland	d tal	To Be	17. Father's Name (First, Middle, Last, BENJAMIN	)	18. Mother's Nar	me (First, Middle, Ma	aiden Sumame)	VOGEL			
lary	2 should and Men is marke aumatic	-	19a. Informant's Name/Relationship (	-	19b. Mailir	-	and Number or Ru		City or Town, State, Zip	Code)	
	tem 27		STEPHEN DANSICK  20a. Method of Disposition		20b. Place of Dispo			-	oc. Location - City or To		
Baltimore,	Pages ment of ant: # i ury or		1 🖾 Burial 2 □ Cremation 3 □ `4 □ Donation 5 □ Other (Specification)	* //	IAL 03/2		REISTERST				
Balt	permit. Departr Importa any inji		22. Name and Address of Facility SOL LEVINSON & BROS., INC.  8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one-cause on each line.								
ı			23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final			er the mode of dying	g, such as cardiad	or respiratory arres	7.	Approximate Interval Between Onset and Death	
	Pnysician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):								
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequence of):						
	certificate be executed iding physician and ise as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a consequence of):						
8760,	ate be e shysicial the buri	edicai		d.							
Box 6	certific Iding p	n/Mec	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Date of deliv	ery	
P.O. Bo	0 0	Physician/M	in the past 12 months? 1 Yes 2 No 9 Unknown	1 □ Live birth 4 □ Pregnant a 9 □ Unknown		Ectopic pregnancy Other (specify)		The state of the s	Month	Day Year	
	w requires that the been signed by th should be detache		Part II. Dther significant conditions of	Contributing to death	but not resulting in the u	nderlying cause give	en in Part I.		cco use contribute to t		
Vital Records,	The law ate has b page 2 st	Completed by						24a. Was an autopsy performe	prior to co	ppsy findings available impletion of cause of	
Vita	Physician: this certificated director,	Be	25. Was case referred to medical examiner?	Hospital:		Othe	ar /	ath (Check only one,			
)	ding Phys h. After this funeral di	n: To	1 Yes 2 No 27. Manner of Death	1 ∐ Inpati 28a. Date of Inj (Month, Da	ury 28b. Time of Injury	IT 3 DOA	4 Wursing F	fome 5 ☐ Residen 28d. Describe how	ce 6 Other (Special injury occurred	(y)	
Division	al or Attending F s after death. Il Director: After ed in by the funera	icatio	1 Natural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not be	in .	jury - At home, farm, str	M 1 🗆 `	Yes 2□No	29f Location (Stro	et and Number or Run	al Route Mumber	
Div	s after al Direct	Certification:	4 Homicide determined	building, e	tc. (Specify)	eet, factory, onice		City or Town,	State)	arriodo Hambor,	
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	edicai	29a. Certifier 1 Certifying PI (Check only one) 1 Medicel Example 1	hysician: To the best miner: On the basis of and manner s	t of my knowledge, death of examination and/or in tated.	h occurred at the tim vestigation, in my op	ie, date and place pinion, death occu	o, and due to the cau irred at the time, dat	ise(s) and manner as s e and place, and due t	stated. o the cause(s)	
	To To To To To To To To To To To To To T	Σ	29b. Signature and title of certifier	Mon.	me	29c. License	PP2		d. Date signed (Month,		
7	)		30. Name and address of person who		Briner (	Print)	Porsa K	Perfact	mi mi	21156	
	Sta Regist		31. Date filed (Month, Day, Year) MAR 2 8 2005	32. Regist	rar's Signature	,					

			For State Registrar	State of	Maryland / De	partment of F e <i>rtificate of</i>			jiene 20	05 10398
			1. Decedent's Name (First, A					2. Date of Dea Month	th	3. Time of Death
	Physici /Medio		DANIEL LOU	IS EDELSTEIN				MARCH	18, 2005	3.00A M
	Examir		4a. Facility Name (If not insti		ber)		or Location of Death		4c. County of	Death FIMORE
			28 GLENBER		7. Age (In yrs. last birthda		ENIX  If Under 24 Hrs.	8. Date of Birth		
	Funeral Director		148-42-7988	1 M 2 F	53 Yrs.	Months Days	Hours Min.	DEC. 7	, Year) , 1951 I	9. Birthplace (State or Foreign Country) NEW YORK
	ъ ,		Usual Residence of Deceder					7	, 1,31	
	show	-	10a. State 10b. Co		10c. City, Town or					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	the M	ecto	MD. B.	ALTIMORE	FIO	ENIX 10f. Zip Code			l0g. Citizen of Wh	
	3a or	ā	28 GLENBERR	Y CT.		101. Zip 0000	21131		UNITED S	
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-1 show or other traumatic event, If a Medical Exerting to restrict the Intiffical at	by Funeral Director	11. Marital Status  1 Never Married 2 3 Widowed 4 Divo	Armed For Married 1 17 Yes	2 🗆 No	3. Was Decedent of I If Yes, specify Cub		ecify Yes or No- Rican, etc.)		American Indian, White, etc.  WHITE
2-0	72 hou	ted		edent's Education ighest grade completed)	16a. De	cedent's Usual Occup ve kind of work done	pation	ina	16b. Kind of Busi	
21	ithin Je.	Completed	Elementary/Secondary (0-	12) College (1-	4or 5+)	. DO NOT use retire	d)			& GAMBLE
	filed w Hygier other th		17. Father's Name (First, Mic	4+	GLO.	BAL OPERAT			MANUFACT	
and	d be f ental h red of	To Be	LEON EDELST					CA KOURY	walden Sumame)	
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	and 2 salth a n 27 la		ELIZABETH E	DELSTEIN/WIF	E 28 (	GLENBERRY	CT., PHOE	CNIX, MA	RYLAND 2	1131
Baltimore,	Pa nen ant: ury		20a. Method of Disposition 1 ☑ Burial 2 ☐ Crema' 1 ☐ Donation 5 ☐ Oth	tion 3 □Removal from S er <i>(Specify)</i>	tate cemetery, c	position (Name of rematory or other pla INT CEMETE	ce)		AIGHLAND NEW YORK	FALLS,
Balt	permit. Departr Importa any inj		21. Signature of Funeral Ser	vice Licensee Ev	ans	22. Name and Addre	Cr.			& SON, INC. YLANU 21224
8760,	The law requires that the death certificate be executed a consistent of the attending physician and consistent of the attending physical and consistent of the attending physician and consistent of t	dical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last	b. Due to (c	or as a consequence of): or as a consequence of):	er				Onset and Death OCH 2000
9	entifica ling ph e as th	Med	IF FEMALE:							
P.O. Box	that the death certificated by the attending placed for use as to	Physician/Me	23b. Was decedent pregnan in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐Live bi	int at time of death	BEctopic pregnanc	у		23d. Date of Month	
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I Records,	iician: The law requ certificate has been rector, page 2 shoule	Completed						24a. Was a autops perform	ry prio	re autopsy findings available or to completion of cause of ath?  Yes 2 \( \subseteq \text{No} \)
/ita	Physician: this certificanal director.	Be	25. Was case referred to me examiner?	Hospital:		04	26. Place of Deat	h (Check only or	(6)	
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Division of Vital	I or Attendi after death. I Dire tor: A d in by the fu	Certification:	3 Suicide 6 □ C	ould not be 28e. Place	of Injury · At home, farm, g, etc. (Specify)	street, factory, office		28f. Location (Si City or Town	reet and Number n, State)	or Rural Route Number,
	To the Hospital or Attending Physician: The Within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical C	29a. Certifier 1 Cer (Check only 2 Med	tifying Physician: To the lical Examiner: On the ba and mann	sis of examination and/or	ath occurred at the ti investigation, in my o	me, date and place, opinion, death occur	and due to the cred at the time, d	ause(s) and mann ate and place, and	er as stated. I due to the cause(s)
	To the within To the comp	M	29b. Signature and title of ce	// /	MI	29c. Licens	3970	2	9d. Date signed (I	Month, Day, Year) 23, 2005
	10		30. Name and address of pe			e, Print)	1 1650	a Kan	ut Be	17,402123;
	Sta Regist	rar	31. Date filed (Month, Day, )	(ear) 32 Re	gistrar's Signature	este)				14,110 2123;

			For State Registrar	State	of Marylar		artment of rtificate o			lental Hy	giene Reg. No. 7			
	o. Physicia		1. Decedent's Name (First, Middl							2. Date of De Month March 2	ath C	Year	3. Timelo 2:15	0 1 1
	/Medic Examin		Lydia ( 4a. Facility Name (If not institution		number)		4b. City, Town	, or Location		marcii 2		ounty of Dea		A
	;		Augsburg Li	utheran H	lome			Balti	more			Balti	imore	
	Funeral Director		5. Social Security Number 219-01-1855	6. Sex 1 ☐ M 2 🖾 F	7. Age (In yrs. 85		If Under 1 Yes Months Day		or 24 Hrs. Min.	8. Date of Bir (Month, Da Apr. 2	th Year) 0, 191	9. Bin	thplace (State of	or Foreign
ī	pur *		Usual Residence of Decedent  10a. State 10b. County		10c Cit	ty, Town or Lo	cation						10d. Inside C	ity Limite
	Aaryla f sho	o			100. 01	ly, rount of Lo		1.11						2 No
	28a-	rect	Md. B	<u>altimore</u>			Perry 10f. Zip Code				10g. Citizer	n of What Co	ountry?	
	h with	al Di	8920 Parlo R	load				21236	5			USA		
	ems a	Funeral Director	11. Marital Status		ecedent Ever in U Forces?	I.S. 13. \	Was Decedent of f Yes, specify C			ecify Yes or No	- 14.		erican Indian,	
2020	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23e or 28e-f show event, the Mudical Exercities reast be inclibed at	by	1X Never Married 2 Marri 3 Widowed 4 Divorced	ried 1XXYes	2 □ No		1⊡Yes 2 <b>X</b> □N			,		ancihe:	hite	
ה ה	72 h	Completed	15. Deceden (Specify only highe	it's Education st grade completed	d)	(Give	dent's Usual Occ kind of work do	ne durina ma	ost of worki	ng	16b. Kind	of Business/	/Industry	
V	within ane.	mp	Elementary/Secondary (0-12)	College	(1-4or 5+)		Cabla C	,			Mosto	.wn []	aatmia	
V	Hygie Hygie thar i	ပို	12 17. Father's Name (First, Middle,	Last)			Cable C		her's Name	(First, Middle			ectric	
ylan	2 should be filed with and Mental Hygiene. Is marked othar than aumatic evant, It a	To Be	Karl			-			01	lga Kon	nert	,		
2	d 2 sh th and 7 Ism traum		19a. Informant's Name/Relations Mr. Ronald Scha		11		mmon Ass							
ב ט	1 and Health tem 27		20a. Method of Disposition	т т лерпе	20b. F	Place of Dispo	mmen Avensition (Name of	1		nium, M Date			Town, State	
2	Pages nent of I int: If its iry or o		1 XBurial 2 Cremation 4 Donation 5 Other (S		n State		natory or other p Cemeter	· 1	3/26/	05	Baltim	nore.	Marylar	nd
Dallillor	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural", or Items 23a or 28a-1 show appringury or othar traumatic event, It is Mudical Exacting the realth be a once.		21. Signature of Funeral Service		01	22	. Name and Add	fress of Fac	ility Ruc	k Tows	on Fur	neral	Home, 1	
			23a. Part1. Enter the disease, or shock, or heart failure. List	or lications that	t can sed the deat	th. Do not ente	1050 YO er the mode of d	ying, such a	d IC is cardiac o	OWSON , or respiratory a	Maryld rrest,	and 21	Approximat Interval Bet	te tween
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	/Medical Examiner		resulting in death)	Due to	o (or as a conseq	quence of):								
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	icate be executed physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c										
200	be exe		resulting in death) Last	Due to	o (or as a conseq	quence of):								
0	physi s the b	edical		d					•					
5	n certif	n/Me	IF FEMALE: 23b. Was decedent pregnant		utcome of pregna		lc				23d	. Date of deli	ivery	
5	uires that the death certific signed by the attending F d be detached for use as	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		birth 2 Feta gnant at time of d known		Ectopic pregnar Other (specify)					Month	Day *	Year
Ĺ	s that ned by e deta	by Ph	Part II. Other significant condition	ons contributing to	death but not res	sulting in the ur	nderlying cause	given in Parl	t I.	23e. Did t	obacco use	contribute to	the cause of d	leath?
cora,	w require been sig should b									1 🗆 '	Yes 2□N	lo 3∏Pr	obably 4 🖃	Inknown
מטט	sician: The law r. certificate has be irector, page 2 sh	ompleted									rmed?	prior to death?	utopsy findings completion of c	available ause of
110	an: T tificate tor, pa	e C	25. Was case referred to medica	1				26 Plac	ce of Death	1 Yes	2 No	1 L Yes	2□ No	
>	ysick is cer direct	OB	examiner? 1 Tes 2 No	Hospital: 1	Inpatient 2	ER/Outpatien	t 3 DOA			ne 5□Resid		Other (Spec	cify)	==
5	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours alter death.  To the Funeral Director: After this certificate has been signed by the attending for onplotely filled in by the funeral director, page 2 should be detached for use as	tion: T	27. Manner of Death  1 Natural 5 Pendir 2 Accident investi	ng (Mo	e of Injury onth, Day Year)	28b. Time of Injury	28c. In W		2	28d. Describe			,	
<u> </u>	or Attenctive death	Certification:	3 Suicide 6 Could 4 Homicide determ	not be 28e. Plac	ce of Injury - At he ding, etc. (Specif	ome, farm, stre fy)	et, factory, office	е	2	28f. Location (S City or Tox	Street and No	umber or Ru	ıral Route Num	ıber,
2	To tha Hospital or At within 24 hours after or To tha Funeral Dirac completely filled in by		29a. Certifier 1 Certifyir	ng Physician: To the	he best of my kno	owledge, death	occurred at the	time, date a	and place, a	and due to the	cause(s) and	d manner as	stated.	
	in 24 h	edical	(Check only 2 Medical one)	Examiner: On the	basis of examina inner stated.	ation and/or inv	restigation, in m	opinion, de	ath occurre	ed at the time,	date and pla	ice, and due	to the cause(s	)
	with To t	Σ	29b. Signature and title of certifie		<del>-</del>			nse number				•	h, Day, Year)	
	- 1		> xauen =					028	646		Marci	n 23	, 2005	
2	5+1		30. Name and address of person KOPPO L. BG	who completed ca	use of death (Item	п 23a) (Туре, I 5 <i>МСі</i> Л	Stree-	t, swi	te 20	o, Re	isters	pown	MD 2	1136
• · ·	Sta Registr		31. Date filed (Month, Day, Year)	2005	Registrar's Signa	ature Ace	We .							

			1 - State Registrar	State of Ma	ryland / Depa		lealth and N	Mental Hygi	•	INLAN
	Physic		Decedent's Name (First, Middle, Las Lola Mae		nrauch			2. Date of Death	4 <sup>, Day</sup> 2005 <sup>Yeer</sup>	3. Time of Death 4:27 a M
	/Medi Examir		4a. Facility Name (If not institution, give				r Location of Death		4c. County of Dea	ath
	Funeral Director		5. Social Security Number 6. Security S	9x 7. Age	(In yrs. last birthday) B2 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, January 15	9. Bi	rthplace (State or Foreign country) TyLand
	ne Maryland 8a-f ehow	ector	MD Baltim	ore	10c. City, Town or Lo	nore				10d. Inside City Limits 1 ☐ Yes 2X No
	th with the 23e or 2	Funeral Director	10e. Street and Number 8421 Oakleigh Ro	ad		10f. Zip Code 21234		10	g. Citizen of What C	ountry?
980	be filed within 72 hours after death with the Maryland that Hygiene. sd other then "neturel", or items 23e or 28e-f ehow event, the Medical Evail in crimit by redifficial at	by Funer	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:	0	Vas Decedent of F f Yes, specify Cub I ☐ Yes 2 No	lispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify:	
Maryland 21215-0036	filed within 72 ho Hygiene. Ither then "netur ant, the Medical	Completed by	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5-	(Give	tent's Usual Occup kind of work done DO NOT use retire	during most of work d)	sing 10	Sb. Kind of Business	,
yland 2	ed all all o	To Be C	17. Father's Name (First, Middle, Last) Ross Joseph					e (First, Middle, Ma		Brendel
	1 and 2 steam 27 is sm 27 is ther trau		19a. Informant's Name/Relationship (7 <b>utilliam K. Eisenraud</b> 20a. Method of Disposition	,III-son		Pamblewood	Rd., Ellica	ott City, M	City or Town, State,  21042  Oc. Location - City or	
Baltimore,	permit. Pages Department of I Importent: If ite any injury or of once.		1 ☐ Burial 2 🂢 Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify  21. Signature of Funeral Service Liceo	)	Hilltop Ser	vice Corpor	ration 3/29,		Towson, MD uneral Home,	, Inc.
	rnysician /Medical		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	. soute	the death. Do not enter.	er the mode of dyir	f., Towson, ng, such as cardiac		t,	Approximate Interval Between Onset and Death One Month
760,	te be executed ysician and be burial-transit	cai Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to luf as a	consequence of):  hue had  consequence of):  hkshil  consequence of):	toline bled				7 years 3 meetes
.O. Box 687	The law requires that the death certificate ite has been signed by the attending physioage 2 should be detached for use as the last	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ Mo 9 □ Unknown	d	Petal death 3 ☐	Ectopic pregnancy Other (specify)			23d. Date of de Month	olivery Day Year
α.	w requires that been signed b should be dete	by	Part II. Other significant conditions co	entributing to death bu	t not resulting in the ur	iderlying cause giv	en in Part I.		_	o the cause of death?
Vital Records,		Completed						24a. Was an autopsy performe	prior to death?	utopsy findings available completion of cause of
of	Attending Physicien: T r death. ector: After this certificat by the funeral director, pa	To Be	25. Was case referred to medical examiner?  1 Yes 2 No 27. Manner of Death  1 Natural 5 Pending investigation	Hospital: 1 Inpatier 28a. Date of Injury (Month, Day	t 2 ER/Outpatien  28b. Time of Injury	28c. Injun Wor	er: 4 ☐ Nursing Ho	th (Check only one) ome 5 President 28d. Describe how	ce 6 Other (Spe	icify)
Division	i Siri de	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	building, etc.				City or Town,		
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	Medical	29a. Certifier (Check only one)  1 ☐ Certifying Phy 2 ☐ Medicel Exem 29b. Signature and title of certifier	rsicien: To the best of iner: On the basis of and manner stat	ed.	estigation, in my o	pinion, death occur	red at the time, date	and place, and due	e to the cause(s)
<b>A</b>			23b. Signature and title of certifier			DS	3445	290	$3-24-2\epsilon$	705
5	- 91		30. Name and address of person who c	ompleted cause of de	ath (Item 23a) (Type, I	Print) PSCER DA	. suite.	BU Tors	on, W	21204
	Sta Registr		31. Date filed (Month, Day, Year) MAR 2 8 20	32. Registrat	ath (Item 23a) (Type, I W 7640 's Signature	will.				

The law requires that the death certificate be executed attending physician and for use as the burial-transit Division of Vital Records, P.O. Box 68760, signed by the a been has certificate or Attending Physicien: this

Baltimore, Maryland 21215-0036

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Zoo 5 Month **Physician** zti ezipin Gladhill March Diehl 23 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hagerstown Washington Washington County Hospital If Under 1 Year | If Under 24 Hrs. | Hours | Min. 6. Sex 1 M 2 ☐ F Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Months 96 Director Jan. 26, 1909 217-32-1317 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ont: If item 27 is marked other then "natural", or items 23a or 28e-1 show 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 7 is marked other then "natural", or items 23a or 28e-f show treumatic event, it a Madical Examinar must be natified at 1 ☐ Yes 2X No Damascus Director Montgomery Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20872 10910 Bethesda Church Road United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes X No Specify: Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Machine dealer Farm Equipment 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Franklin S. Gladhill Mollie Baker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernardine G. Beall-Daughter 25911 Clarksburg Road, Clarksburg, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 △Burial 2 □ Cremation 3 □ Removal from State Date 20c. Location - City or Town, State pernit. Page Department of Importent: If any injury or Damascus United Meth. 03-28-2005 Damascus, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 811mond Admond Esworth, P.A. Funeral Home 26401 Ridge Road, Damascus, MD 23a. Part1. Enter the disease, or combigations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only or e cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Preumonia disease or condition resulting in death) Buscks /Medical Due to (or as a consequence of): Examiner sphagia VEO. IT Sequentially list conditions, if any, leading to immediate Enter Lindarying Cause (Disease or injury Due t (or is a consequence of): Examiner that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Mellitus 1 Yes 2 No 3 Probably 4 Unknown Completed Heart 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an estive autopsy performed? Renal Failure 1 Yes 2 No 1 ☐ Yes 2.**D**Ko Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Mnpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) within 24 hours after death.

To the Funerel Director; After thi completely filled in by the funeral 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation М 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D47451 Synthea Kuttner-Sands and March 24 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Church Road, Hagerstown Kuttner-Sands no 14214 Paradise Cynthia Maryland 34 Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

MAR 2 8 2005

			For State Registrar	State of I	Maryland		artment <i>tificate</i>			ind M	ental Hy	giene Reg. No		may on the same	0402
	Dhusiai		1. Decedent's Name (First, Middle	e, Last)						Ī	2. Date of De	ath Da	у Үөөі		Time of Death
	Physici /Medi		Ann	Griffis							March		3 2005		1:08 A <sup>M</sup>
	Examir	ner	4a. Fecility Name (If not institution				4b. City, To		ocation of	f Death		4c	. County of De	ath	
			Southern Maryl 5. Social Security Number			4 6 i-46 - 1 1	Clin		If Under 2	A Hrc		P1	rince G	eorg	;e
	Funeral Director		244-22-9406	6. Sex 7. 1 ☐ M 2 ☐ F	Age (In yrs. la 85	ast <i>birthd</i> ay) Yrs.		Days	Hours	Min.	(Month, Da	th ber her	15.191	ountry)	(State or Foreign NOT Th
			Usual Residence of Decedent										13,451.	' Ca	rolina
	urylan show	_	10a. State 10b. County			, Town or Lo									nside City Limits
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	72 hours after deeth with the Maryland naturel', or Items 23a or 28e-f ehow Alfeel Examil at must be notitled at	Funeral Director	10e. Street and Number 2704 Old Barna	hy Road			10f. Zip C	ode 20748					izen of What C		
	eeth	erai	11. Marital Status	12. Was Decede	nt Ever in LLS	S 13 V				in? /Spo			ed Star		dian
(0	r Iten	Fun	1 Never Married 2 Marri	Armed Force	s?	ı			Mexican,	Puerto f	cify Yes or No Rican, etc.)	_	Black, Wh	ite, etc.	
030	ours a	þ	3X Widowed 4 □ Divorced	If Yes, Give Year or Date	s:		I□Yes 2¥	☑ No	Specify:				Specify:	Blac!	k
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121	within lene. then *	mpi	Elementary/Secondary (0-12)	College (1-4d	or 5+)		kind of work OO NOT use						ted Sta		
7	filed withi Hygiene. other then		Twelth  17. Father's Name (First, Middle, )	l ast)		UI	fice A				(First, Middle		eral Go	over	nment
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ary	2 should I end Meni is marker eumatic	ſ-	19a. Informant's Name/Relationsh										r Town, State,		
	1 and 2 Heelth		Cecile Johnson/	Niece						oad,	Temple	Hil	ls Mary	/land	d 20748
Baltimore,	pes 1 t of H if Iter or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 □Removal from Sta	20b. Pla	ace of Dispo emetery, cren	sition (Name natory or oth	of er place)	М	arch	ate	20c. Lo	ocation - City o	r Town, S	State
Ē	men men tant:		`4 ☐Donation 5 ☐ Other (Sp	pecify)		Linco				4,20		Bren	twood 1	[ary]	land
Bal	permit. Pages 1 Department of F Important: if Ite any in ury or ot	ļ,	21. Signature of Funeral Service I	Licensee									n Funei		
=			23a, Part1. Enter the disease, or	complications that cause	sed the death								ton DC		20 roximate
	Physician		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final	only one cause on each	n line.	7	A . /	/	1.6	- 11		11031,		Inter	rval Between et and Death
	/Medical		disease or condition resulting in death)	a. Due to (or	assconsequ	ence of):	val rest.	10	Jan	U	-0N			(h)	Know
5	Examiner		Sequentially list conditions	b	/	401	un/	en	8101					lan	Hnown
4	ם יו	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consequ	ence of):									
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687	ificate g phys	edic		d.								Too.			
Вох	eath certific attending pl	m/m	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor			C-+i					2	23d. Date of de	livery	
		sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		2 Fetal of dea		Ectopic preg Other (spec						Month	Day	Year
P.0	that the de led by the a detached t	Physician/Med	9 Unknown												
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Vital Records,	0 5	Completed									24a. Was autop perio		prior to death?	completi	ndings available ion of cause of
tal	icien: Th certificete rector, pag	e Cc	25. Was case referred to medical		~			2	e Place	of Doorth	1 Tes	2 No	1 🗆 Yes	3 2 n	No
>		0	examiner? 1 ☐ Yes 2 ☐ 1/6	Hospital:	atient 2□E	R/Outpatient	3□ DOA	04			Check onl o		S □Other (Spe	sciful	
n of	ding Phys n. After this funeral di	n: T	27. Manner eath	28a. Date of Ir		28b. Time of Injury		Injury at Work?			3d. Describe I			iony)	
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Division	i or Atten efter deati Director:	Certification:	3 Suicide 6 Could n 4 Homicide determi	ned 286. Place of	Injury - At hor etc. (Specify)	ne, farm, stre	et, factory, o	office		2	Bf. Location (5 City or Tox	Street and vn. State	d Number or R	ural Roul	te Number,
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	To the Hospital or Attending Ph within 24 hours efter death. To the Funerel Director: After th completely filled in by the funeral	edicai	(Check only 2 Medicel E	g Physician: To the be Examiner: On the basis and <i>m</i> anner	of examination	on and/or inv	estigation, in	my opini	ion, death	piace, ai occurre	d at the time,	date and	and manner a place, and du	s stated. e to the c	cause(s)
	To the Hospital within 24 hours e To the Funeral i completely filled	Me	29b. Signature and title of certifier	1			29c. L	icense n	u <i>m</i> ber			29d. Date	e signed (Mon	h, Day, 1	Year)
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i			30. Name and address of person v	vho completed cause o		23a) (Type, F	Print)	( -	2.						
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	Physici /Medio			MYRON		D.		GOLDFAR	В	MARCH			
1	Examin				e street and number)	10.	-0.35	4b. City, Town,	, or Location of Deal		4c. Coun	ty of Death	
	Funeral		5. Social Security I	Number 6. S		e (In yrs. last		V3AL If Under 1 Yea			rth	9. Birthp	N/A lace (State or Foreign try)
	Director		145-20	-3003	XM 2□F	77	Yrs.	Months Day	s Hours Min	8. Date of B (Month, D JAN. 29	9,1928	Cour	NY
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	e Man Ba-fah	ctor	MD	BAL	TIMORE		CATO	NSVILLE					1 ☐ Yes 2 ☐ No
	with th	Director	10e. Street and Nu		VENUE			10f. Zip Code			10g. Citizen o	f What Cour	-
	ns 23	Funeral	1/ HUL 11. Marital Status	MEHURST A	12. Was Decedent	Ever in U.S.	13.		21228 f Hispanic Origin? (Suban, Mexican, Puer	Specify Yes or N	o- 14. Ra	ace - Americ	USA an Indian,
5-0036	filed within 72 hours after death with the Maryland Hyglene. thar than "natural", or Items 23a or 28a-f ahow thir, the Modical Exac illustrates redified at	þ		ried 2 Married 4 Divorced	Armed Forces? 1 X Yes 2 □ I If Yes, Give Year or Dates:	No KORE	A	lfYes, specifyCu 1□Yes 21X/N		to Rican, etc.)	Spec	ack, White,	
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Ball	permit. Pag Department Important: I any injury o		21. Signature of F	uneral Service Licer	attle			2. Name and Add	I <sup>ress of Facility</sup> SI STERSTOWN	OL LEVIN _ROAD -			
	Pnysician /Medical Examiner		23a. Partt. Enter shock, or her shock, or her limmediate Cause disease or conditionsulting in death)  Sequentially list or	art failure. List only (Final on	plications that caused one cause on each line.  a Due to (or as b.	ne. LStati	, C		ying, such as cardia		arrest,	,	Approximate Interval Between Onset and Death ANKOUW
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Division	To tha Hospital or Attanding P within 24 hours after death. To tha Funaral Diractor: After t completely filled in by the funera	Certification:	2 Accident 3 Suicide 4 Homicide	6 Could not be determined		ury - At home c. <i>(Specify)</i>	, farm, str			28f. Location ( City or To	Street and Num wn, State)	iber or Rura	Route Number,
	Hospita 4 hours Funaral ely fille	Medical Co	29a. Certifier (Check only one)	1 ☐ Certifying Ph 2 ☐ Medical Exam	ysician: To the best niner: On the basis of	f examination	dge, death	n occurred at the vestigation, in my	time, date and place	e, and due to the arred at the time,	cause(s) and m	nanner as sta , and due to	ated. the cause(s)
	Vithin 24	Med	29b. Signature and	1 title of certifier	and manner sta	100.		29c. Licer	nse number		29d. Date sign	ed (Month, L	Day, Year)
	d		) I	· 0	raen			p	16845		MARCI	it 22	2005
3	0		NAVE	EEN P	completed cause of d	leath (Item 23	3a) (Type,	Print)	VENUE	BAL	TIMO	REI	2005
••	Sta Registr		31. Date filed (Mor	nth, Day, Year) R 2 8 2005		ar's Signature	Coon	E)		-			

			04-4-	partment of Health and Nertificate of Death		ene	1
	Physic	ian	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month		3. Time of Death
	/Medi	cal	Elizabeth B. Hittle		March	24 2005	2:15 A M
	Exami	ner	4a. Facility Name (If not institution, give street and number) LOOKabout Manor, Inc.	4b. City, Town, or Location of Death Westminster		4c. County of Death Carroll	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	g. Birthi	place (State or Foreign
	Director		219-12-3421 1 M 2 M F 80 Yrs.	Months Days Hours Min.	Dec. 12	rear)   Cou	MD MD
	land		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or	Location			10d. Inside City Limits
	Mary a-f sh	to	Maryland Carroll	Mt. Airy			1 ☐ Yes 2 ☑ No
	rurs after death with the Marylan sil, or Items 23e or 28e-f show Examiner mast be mutified at	Director	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Cou	ntry?
	s 23a	ral	17526 Woodcamp Road	21771		USA	
10	ter de tem	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married 1 Yes 2 1 No.	. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
036	ours a	by	3 X Widowed 4 □ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: Wh	nite
21215-0036	d within 72 hours after death with the Maryland liene. r than "naturel", or tlems 23e or 28e-f show the Medical Examiner coast be notified at	Completed	(Specify only highest grade completed) (Given	edent's Usual Occupation se kind of work done during most of work	ina 16	b. Kind of Business/In	dustry
121	within ene. than	Jumo	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)			
d 2	filed Hyg ant,	Be Co	17. Father's Name (First, Middle, Last)	Teacher  18. Mother's Name	e (First, Middle, Ma	nne Arunde	el County
/lar	2 5 5 9	To B	Raymond L. Duvall	Helen	Clayton	Cook	
Maryland	and and ls m		19a. Informant's Name/Relationship (Type, Print)  19b. Ma	ling Address (Street and Number or Rura	al Route Number, C	City or Town, State, Zip	Code)
	Health Health tem 27		Laura L. Hartman (daughter) 175  20a. Method of Disposition 20b. Place of Disp	26 Woodcamp Road, I			0
Baltimore,			- A some	position (Name of ematory or other place)  March Yen Cemetery 200		c. Location - City or To	
alti	permit. Page Department o Importent: If any injury or once.		21. Signature of Funeral Service Light earl	22. Name and Address of Facility		len Burnie,	
_	9 9 5 5			3111 Mountain Rd.,			Home P.A.
			23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac o	or respiratory arrest		Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)				Onset and Death
	Examiner		Due to (or as a consequence of):				
	P #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. Enter Underlying that initiated events c.				
	and errans	Examiner	that initiated events resulting in death) Last Due to (or as a consequence of):				
8760,	cate be executed physician and the burial-transit	dical E	Due to (or as a consequence of).				
9	tificate ig phy as the	ledic	0.				
Вох	death certific e attending p od for use as	an/M	IF FEMALE: 23b. Was decedent pregnant   23c. If yes, outcome of pregnancy   1 □ Live birth   2 □ Fetal death   3	□Ectopic pregnancy		23d. Date of delive	ery
0.	the dea y the at iched fo	yslcl		Other (specify)		Month	Day Year
<u>α</u>	that the death hed by the atter detached for u	Completed by Physician/Me	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	co use contribute to th	e cause of death?
Division of Vital Records,	The faw requires that ate has been signed by page 2 should be deta	q pa	Dishetes mellits I		1 🗆 Yes		. /
eco	e law re has bed je 2 sho	plet	Dyg Imelemia		24a. Was an	24b. Were autor	osy findings available
<u>=</u>		Corr			autopsy performed 1 Yes 2 2	death?  No 1 ☐ Yes	npletion of cause of 2M2 No
Vit	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?  Hospital:	26. Place of Death		-/-	Driver Line
10	g Physer this eral di	P-1	27. Manner of Death 28a. Date of Injury 28b. Time	4 Nursing Hon	ne 5 Residence 28d. Describe how i	e 6 Other (Specify	Core
sior	Attending Isr death. ector: After by the funer	atio	2 Accident investigation	Work? M 1 Tyes 2 No			
Ĭ Ķ	or Attence after death Director: in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, si building, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural late)	Route Number,
	Hospitel 24 hours a Funerel E		29a. Certifier 1/2 Certifying Physician: To the best of my knowledge, dea	The account of the state of the			
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical	(Check only 2 Medical Examiner: On the basis of examination and/or in and manner) stated.	in occurred at the time, date and place, a evestigation, in my opinion, death occurre	ed at the time, dato	e(s) and manner as sta and place, and due to	ated. the cause(s)
	To the within 2 To the comple	×	29b. Signature and title of certifier	29c. License number		Date signed (Month, L	
K	2		· WOUM M	) 13359	9	03/25/3	2005
5	/		30. Name and address of person who completed cause of death (Item 23a) (Type Philip Ruzbarsky, M.D., 125 Al rport	Print) Drive Westminston	MD 2115	7	
Z	Sta	te	31. Date filed (Month, Day, Year) 32. Restrar's Signature	bi ive, wesuminister	, אט בווס	1/	
1/2	Registr	ar	MAR 2 8 2005 Maria 18	Society			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 11, 16a, b. per FH, C841, 03/28/05dhb
State of Maryland / Department of Health and Mental Hygiene
Amend Items 28a-f per ME, C841, 163/22/05/05/06hb Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 01 Day **Physician** 2118 M Shirley Holder /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shock Bostinuore Maryland 1 Fauma Boltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex . 5ex 1□M 2⊅F Funeral 68 218-38-6961 05/09/1936 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Itams 23s or 28a-f show Baltimore 1 Yes 2 No Baltimore MD Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2412 21217 Francis Street USA 12. Was Decedent Ever in U.S. Amed Forces?
1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 and 2 should be filed within 72 hours after d Health and Mental Hyglene. I am 27 Is marked othar than "naturat", or Itam Thar traumatic event, the Micdral Estatument 1 Never Married 2 Married 1 ☐ Yes 2 No Saltimore, Maryland 21215-0036 Specify: Specify: Black Be Completed by 3 Widowed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) House Keeper 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Doctor's Office Elementary/Secondary (0-12) College (1-4or 5+) P 12tH grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) George Mason Ruth Mason 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21133 Health a itam 27 Is other tra 9913 Cervine Lane Apt 202, Randallstown, Md ArtHur Holder-Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of It Important: If its any injury or of Burial 2 Cremation 3 Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 1/10/05 Randallstown, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 23a. Part1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4300 WabasH Ave, Baltimore, Md 21215 Approximate Interval Between Onset and Death Immediate Cause (Final Shock ptic Physician hours disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Colonic Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner o the Hospital or Attanding Physician: The law requires that the death certificate be executed burial-transit OLON Due to (or as a consequence of) Physician/Medical 3 ☐ Ectopic pregnancy IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Year in the past 12 months? Month Day 4□Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Tuberculosis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Miliary Be Completed Vein Thrombosis 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2. No Hypertension 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending after death. investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗌 Homicide HOME in 24 hours a 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier pletely (Check only one) 29c License number 29d. Date signed (Month, Day, Year) 2 16559 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BHOLAT OMAR 22 South St MS Greens Baltimore 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

MAR 22 2005

**ORIGINAL** 

			1 - State Registrar Cer	artment of Health and Mental rtificate of Death	Reg. No. 2005 10406
	Physici	an	1. Decedent's Name (First, Middle, Last)  Jennie C. Hammond		of Death h 24, Day 2005 Yeer 3. Time of Death 8:10 PM
	/Media		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
1	LXaIIII	iei	Hart Heritage Estate	Street	Harford County
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. 8. Date Months Days Hours Min. (Month	of Birth 9. Birthplace (State or Foreign
	Director		218-22-0014	Aug	29, 1917 Maryland
	yland		10a. State 10b. County 10c. City, Town or Lo	cation	10d. Inside City Limits
	n the Marylan r 28a-f show	Director	Maryland N/A Baltimor	e City	1 Yes 2 No
	with the or 20	Dire	10e. Street and Number 4529 Arabia Avenue	10f. Zip Code 21214	10g. Citizen of What Country? U.S.A.
	leath	Funeral		<u></u>	
9	72 hours after death with the Maryland natural', or Items 23a or 28a-1 show Item Eswrth or must be notified at	Fun	Armed Forces?	Was Decedent of Hispanic Origin? (Specify Yes f Yes, specify Cuban, Mexican, Puerto Rican, etc	Libito
003	72 hours "natural",	d by	3 ☑ Widowed 4 □ Divorced Year or Dates:		Specify.
15	- 10	Completed	(Specify only highest grade completed) (Give	lent's Usual Occupation kind of work done during most of working DO NDT use retired)	16b. Kind of Business/Industry
212	filed within I Hygiene. other than fent, It is Mer	шо	Elementary/Secondary (0-12) College (1-4or 5+)	rvisor	U.S. Government
pu	be filed Ital Hyg ad othe event,	Bec	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, M	
<u>y</u> la	2 should be finand Mental Park is marked of reumatic ever	2	Vincent Chiodi	Maria Crimi	
Maryland 21215-0036	d 2 sh thand Tisrr traum			ng Address (Street and Number or Rural Route A G. Fountain Green_Road	
<u>ə</u>	ges 1 and 2 should it of Health and Mer if item 27 is marke or other traumatic	T (i	20a. Method of Disposition 20b. Place of Disposi	sition (Name of pater)  Date	20c. Location - City or Town, State
E O	Pages 1 and 2 nent of Health ant: if item 27 i		1 Deliar 2 Oremation 3 Memoral non State	Cemetery 3/29/05	Parkville, MD
Baltimore,	permit. Pages Department of Importent: If i any injury or once.			Name and Address of Facility 11er—Dippel Funeral Ho 15 Belair Road Baltin	
	Physician /Medical Examiner	iner	Sa. Part.! Enter the disease, or complications that caused the death. Do not enter shock, debeart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter 'Underlying' Cause (Disease or injury)  Due to (or as a consequence of):	er the mode of dying, such as cardiac or respirat	Interval Between
8760, <	cate be executed obysician and the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last  c		
O. Box 6	w requires that the death certificate been signed by the attending phys should be detached for use as the	Physician/Me		Ectopic pregnancy Other (specify)	23d. Date of delivery  Month Day Year
rds, P.	requires that een signed b	þ	Part II. Other significant conditions contributing to death but not resulting in the un		Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably Unknown
of Vital Records,	The la ate has page 2	Completed			
Z.	Physician: this certific ral director,	) Be	25. Was case referred to medical examiner?  1   Yes 2   Wo   Hospital: 1   Inpatient 2   FR/Outpatient	26. Place of Death Check of Other:	
o	ding Physih.  After this funeral di	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of	3 DOA 4 Nursing Home 5	Residence Cother (Specify)
ion	Attending I ar death. rector: After by the funer	atio	1 Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No	
Division	or Attendate death of Director:	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)		on (Street and Number or Rural Route Number, r Town, State)
	Hospital of the Hospital of Funeral Distely filled in		200 Contine 1 Continue Physician Table 1 (1997)		
	To the Hospital or Attenwithin 24 hours after deati To the Funeral Director: completely filled in by the	edicai	29a. Certifier  (Check only one)  Check only one one of examination and/or invanient stated.	restigation, in my opinion, death occurred at the t	ine cause(s) and manner as stated. ine, date and place, and due to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Year)
			air Ista	D35889	MARCH 25, 2005
/	10			Print) 1. MALPITAI Bel p. M.	
	Sta Registr		31. Date filed (Month, Day, Year)  MAR 2 8 2005	· A · ***	
				7.7	

DHMH 17 Rev 1/2001

ORIGINAL

			4 For	State of M	laryland					ind M	ental Hy	giene	005	10607
			1 - State Registrar			Cen	tificate	OIL	Jeath		2. Date of Dea	Reg. No.		3. Time of Death
	Physici /Medic			esley		ma		-			Month March	25	200.5	5:22 AM
	Examin	er	4a. Facility Name (If not institution, gir		)				Location o	f Death			ounty of Dea	th
			Good Samaratin H 5. Social Security Number 6.	ospital Sex 7.A	ge (In yrs. las	t birthday)	If Under	timo:	re If Under 2	24 Hrs.	8. Date of Birt		1∕a 9. Bir	thplace (State or Foreign
	Funeral Director		212-42-8072	Sex 7. A 1  M 2  □ F	60	Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Da) May 25	, Year) 194	4 Ma	rvland
			Usual Residence of Decedent											
	how		10a. State 10b. County		10c. City, 7	Fown or Loc	ation							10d. Inside City Limits 1 ☐ Yes 2 X No
	Ba-f	cto	MD Baltimo	re	Pa	arkvil								
	it th	Dire	10e. Street and Number				10f. Zip						n of What Co	ountry?
	ath w	rai	1317 Halstead Ro		. F	142.14	1	2123		-:-2 (5	it. Van an Na	USA	Pace - Ame	encan Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene Important: If item 27 is marked other then "natural", or iteme 23a or 28a-f show appringly or other traumatic event, the Medical Examiner must be notified at ance.	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☑ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Deceden Armed Forces 1 X Yes 2 If Yes, Give Year or Dates:	? 1No 04/1	964	Yes, speci		Specify:	gin? (Spe i, Puerto F	cify Yes or No- Rican, etc.)		Black, Whit	
21215-0036	2 hou		15. Decedent's E	ducation		16a. Decede	ent's Usua	Occupa	ition			16b. Kind	of Business	/Industry
215	7 circ	piet	(Specify only highest gi Elementary/Secondary (0-12)	ade completed) College (1-4or	5+)	(Give k life. D	kind of worl O NOT us	k done d e retired)	uring most	of workir	'g			
212	d with giene	Completed	Clamaritary/occordary (5 12)	2		Custom	ner Se	ervi	ce Re	p.		В.0	G. & E	•
	be file tal Hy od othe event,	Be	17. Father's Name (First, Middle, Las	t)							(First, Middle,		итате)	
<u>Ja</u>	should b and Menti marked	2	Edward Herman	Heymann							ary Bec			
Maryland	nd 2 should be filed within and Mental Hygiene. 27 Is marked other then r traumatic event, Ita Ma		19a. Informant's Name/Relationship Anne M. Heymann/								Route Number	-		
ē,	s 1 and of Health item 27 other tr		20a. Method of Disposition		20b. Plac	e of Dispos	sition (Nam	ne of ther place	9)		o/2005	20c. Loca	ition - City or	Town, State
Ë	Pages nent of h ant: If ite ury or o		1 X Burial 2 ☐ Cremation 3 1 4 ☐ Donation 5 ☐ Other (Spec		9 [	neý Va				dens	טייים אני	Timo	onium,	Maryland
Baltimore,	permit. Pages Department of Important: If i any injury or once.		21. Signature of Furnaral Service Life	5.	Coster						k Towsc son, Ma			Home, Inc. 54
	Physician		23a. Fart1. Enter the disease, or conshock, or learn failure. List only Immediate Cause (Final disease or condition	one cause on each	line.					21	respiratory ar			Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	a. Due to (or a	s a consequer	nce of):	lear		,,,,,	, , , ,	· · · · · · · · · · · · · · · · · · ·	7	•	
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or a	s a consequer	nce of):	cer							
,092	ate be executed nysician and he burial-transit	cai Exar	that initiated events resulting in death) Last	C. Due to (or a	s a consequer	nce of):								
687	phys phys s the			d										
Box	The law requires that the death certificate tee has been signed by the attending physioage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal de at time of deat	eath 3 🗌	Ectopic pre Other (spe					23	d. Date of de Month	livery Day Year
P.0	that the ed by detac	P	Part II. Other significant conditions	contributing to death	but not resulti	ng in the un	iderlying ca	ause give	n in Part I.		23e. Did to	obacco use	contribute to	o the cause of death?
ds,	sign d be	d by									101	/es 2 □	No 3□P	robably 4 Unknown
Š	v requ	ete						-			24a. Was	an	24h Were a	utopsy findings available
Il Records,		Completed									autop perfo		prior to death? 1 X Yes	completion of cause of
Vital	Physician: this certific al director,	Be	25. Was case referred to medical examiner?	Hospital:				Othe	10		(Check only o			
of	this ald	<u>P</u>	1 Yes 2 No 27. Manner of Death	28a. Date of In		VOutpatient 8b. Time of		8c. Injury	4 🗆 140		ne 5 Resident			ecify)
L C	fune	ion	1) Matural 5 Pending	(Month, E		Injury	м	Work	(? Yes 2.∐l		.00. 00001100 1	iow inquiry	56541164	
Division	Attending r death. sctor: After by the fune	lical	3 Suicide 6 Could not	be de Bless of I	niury - At hom	e. farm. stre					8f. Location (	Street and	Number or R	ural Route Number,
ο	after Dire	ertii	4 Homicide determine	building,	etc. (Specify)	0, 14111, 0114	, , , , ,	,			City or Tov			
_	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical Certification:	29a. Certifier (Check only one) Medical Exc	hysician: To the besominer: On the basis and manner:	of examinatio	edge, death n and/or inv	occurred a restigation,	at the tim in my op	ie, date an pinion, dea	d place, a	and due to the ed at the time,	cause(s) a date and p	nd manner a lace, and du	s stated. e to the cause(s)
	o the	Me	29b. Signature and title of certifier	- 2		7.5	29c	. License	number		7	29d. Date	signed (Mon	th, Day, Year)
	FIFS	+	> Milan	Lano	u um	1		0.3	3571	04		Mar	h 76	7,005
	1		30. Name and address of person wh	completed cause of	death (Item 2	3a) (Typa F	Print)	-	,376	7	- 1	, 21.	11 6	1 - 5
20	4 /		0.1		d Sam		an i	Hos	ortal	Ba	Hme	e.	2123	7005
	Sta	ate	31. Date filed (Month, Day, Year)	32. Regis	strar's Signatur	re		-	,				/	
	Regist		MAR 2 8 20	15 Hande	. 18	Aran	1/1							

			Please T		ack Indelible Ink. Ensu	-	
			For	State of Maryland	/ Department of Health a	nd Mental Hygie	ne 2005 101.08
			State Registrar		Certificate of Death	Reg.	No. 3. Time of Death
	Physici /Medic	an al	1. Decedent's Name (First, Middle, Last)  Margaret	- Earl	Jackson  4b. City, Town, or Location of	March	Day Year 24, 3605 1:50 4.M
	Examin	er	4a. Facility Name (If not institution, give s	or Assisted	Living Luthervil	le	Bailtimore
	Funeral	-370	5. Social Security Number 6. Sex	7. Age (In yrs. las	st birthday If Under 1 Year If Under 2		
	Director		241-16-3167 Usual Residence of Decedent	M 20 F 97	Yrs.	June 15,	
	ow ow		10a. State 10b. County	10c. City,	Town or Location		10d. Inside City Limits
	within 72 hours after death with the Maryland ene. than "natural", or Itema 23e or 28e-f ahow he Moulcel Exercites must be motified at	Director	MD Baltin	nore L	uther ville	10g	1 ☐ Yes 2 ☐ No Citizen of What Country?
	th with	ai Di	300 W. S	eminary	Ave. 21093		USA
	r deat	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican,	in? (Specify Yes or No- , Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	rs afte	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 █ No If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: 11hite
215-0036	2 hou	Completed by	15. Decedent's Edu (Specify only highest grade	cation	16a. Decedent's Usual Occupation (Give kind of work done during most		b, Kind of Business/Industry
1-	ithin 7	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired)	1	Jorth Carolina
121	e filed withis Il Hygiene. other then vent, the M		17. Father's Name (First, Middle, Last)		Secretar 18. Mother	r's Name (First, Middle, Ma	Wartment of Kevenue
and	ould be f Mental H arked of	To Be	William A	ustin Sa	vage Go	othic To	Sie Savane
Maryland	2 should be and Menta is marked aumatic av	Ė	19a. Informant's Name/Relationship (Ty		19b. Maili Address (Street and Number	r or Rural Route Number, C	ity or Town, State, Zip Code)
	12 E B			erson	1902 Wilson Point	Road Middle	River, MD 21220
ore	0 0		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	emoval from State	ce of Disposition (Name of netery, crematory or other place)		c. Location - City or Town, State
Baltimore,			* 4 □ Donation 5 □ Other (Specify)  21. Signature of Toperal Service License		en wood Cemetery 3		arboro, North Carolina
Ba	permit. Departr Imports any inju		to tille	4 Thanis	Joseph L. Russ	funeral Ho. Bati	more, MD 21216
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the death.	Do not enter the mode of dying, such as	cardiac or respiratory arrest	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Metas	tatic aden	carcino	
	/Medical Examiner		resulting in death)	Due to (or as a conseque	nce of):	-	
4	- Adminio	<u>-</u>	Sequentially list conditions,	)	NICE UT):		
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to introduce cause. Enter Underlying Cause (Disease or injury that initiated events				
60,	be executed icien and burial-transit		resulting in death) Last	Due to (or as a conseque	nce of):		
9289		lical		I			
9 x	leath certificate t attending physic I for use as the b	/Med	IF FEMALE:	3c. If yes, outcome of pregnant	cv		23d. Date of delivery
Вох	atten 1 for u	cian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fetal of 4 Pregnant at time of dea	leath 3 □Ectopic pregnancy		Month Day Year
P.O.	The law requires that the death certificate atte has been signed by the attending physopage 2 should be detached for use as the	Physician/Medic	9 Unknown	9□ Unknown			
	es tha igned be de	by P	Part II. Other significant conditions con	- The	ting in the underlying cause given in Part I.		cco use contribute to the cause of death?
ord	w requir been si should	ted		<del></del>	1 1 1 1 1 1		2 □ No 3 □ Probably 4 □ Unknown
3ec	e law has b	Completed	Advance	el age		24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death?
Vital Records,	ysician: The law is certificate has b director, page 2 s		25. Was case referred to medical		26 Place		No 1 □ Yes 2 □ No
Ž	Physician: this certificanal director, particular	o Be	avaminar?	lospital:		rsing Home 5 Residence	e 6. Other (Specify)
J Of	ing Phys.  After this funeral di	n: T	27. Manner of Death 1 ☑ Natural 5 ☑ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of 28c. Injury at Work?	28d. Describe how	
siol	eath. lor: Af the fu	catic	2 Accident investigation 3 Suicide 6 Could not be	<u> </u>	M 1 Tes 2 1		
Division	or Att	Certification:	4 Homicide determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, street, factory, office	City or Town, S	et and Number or Rural Route Number, State)
_	To the Hospital or Attending Phwithin 24 hours after death. To the Funerel Director: After th completely filled in by the funeral				ledge, death occurred at the time, date and on and/or investigation, in my opinion, deal		
	the hin 24	Medicai	29b. Signature and title of certifier	and manner stated.	29c. License number		. Date signed (Month, Day, Year)
	T W S	_	290. Signature and this of certifier	ieee			3/24/05
	00		30. Name and a bress of person who co	ompleted cause of death (Item :	23a) (Type, Print)	21204	0/2//
_	\		21 West	3	uson, MD	21204	
		ate	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ıre		
DF	Regist		MAR 2 8 2005	Blokus S.	South .		
51					ORIGINAL		

Box 68760,
P.O.
Records,
Vital
of
Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2005 20 HARCH Mildred Jackson /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner SINAI HOSPITAL OF BAUTIMOR BALTIMORE Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** 1 M 200F Months Days Hours Director 08-18-1920 Maryland 220**-**10-6288 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a, State 10b. County rei', or items 23a or 28e-f show Examirer must be nutified at 1 Yes 2 □ No N/A Baltimore Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 3517 Hayward Ave 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Black Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) is marked other than College (1-4or 5+) Elementary/Secondary (0-12) 12 Homemaker House Wife 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) and 2 should be ealth and Mental Francis Henry ပ Emerson Jackson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: if item 27 is any injury or other training. Baltimore, Maryland 21205 Sharon Jackson 737 N. Milton Ave 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Greenmount Cremetory 03-30-2005 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of FacilitWise Funeral Services, P.A. 700 S. Beechfield Ave Baltimore, Maryland 21229 rester have 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final to we obstruction **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter of crying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit Due to (or as a consequence of): the attending physician law requires that the death certificate be Physician/Medical the use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day ò 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 99 1 Yes 2 No 3 Probably 4 Unknown pleted 24a. Was an certificate has autopsy performed Com 2 🗆 No or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes After this funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending 1 Tyes 2 🗆 No To the Hospitel or Attendii within 24 hours after death. To the Funerel Director: A investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2005 30. Name and address of erson who completed cause of death (Item 23a) (Type, Print) HOSPITAL OF BALTIMORE NW 31. Date filed (Month, Day, Year) State MAR 2 8

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

2005

			. FOI	partment of Health and Nertificate of Death		ene	
	Physici	an	Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
•	/Medic Examir		Marie B. Krall  4a. Facility Name (If not institution, give street and number)  Stella MAris Hospice	4b. City, Town, or Location of Death  Towson		23 2005 4c. County of Death Baltimore	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 218-42-6496 1 M 2 F 96 Yrs.	y) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, May 20	year) , 1908 MAry	ace (State or Foreign Land
	death with the Maryland ms 23a or 28a-f show fritted at	ctor	10a. State 10b. County 10c. City, Town or	Location SSEX		10	0d. Inside City Limits 1 ☐ Yes 2 💆 No
	with th	Director	100. Street and Number 1000 Franklin Ave,	10f. Zip Code 21221	10	g. Citizen of What Count USA	ry?
20		by Funeral		Was Decedent of Hispanic Origin? (Sp     If Yes, specify Cuban, Mexican, Puerlo     □ Yes	ecify Yes or No- Rican, etc.)	14. Race - America Black, White, e	tc.
0500-6121	within 72 hours after ene. than "neturel", or ite tre Medical Examilla	Completed I	15. Decedent's Education (Specify only highest grade completed)  [Gin Gin Gin Gin Gin Gin Gin Gin Gin Gin	sedent's Usual Occupation re kind of work done during most of work . DO NOT use retired) Omemaker	ring	6b. Kind of Business/Indi	
and 2	12 should be filed within? n and Mental Hygiene. r Is marked other than "reumatic event, the Med	To Be Co	12th 17. Father's Name (First, Middle, Last) Ignatius Matousek	18. Mother's Name	e (First, Middle, M rine Syl	laiden Surname)	
lary	2 shoul and Marl Is marl	-		iling Address (Street and Number or Run	al Route Number,	City or Town, State, Zip (	Code)
nore, I	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other treumatic ev		20a. Method of Disposition 1 ☐ Buriat 2 ☑Cremation 3 ☐Removal from State 20b. Place of Disposition cometery, or	5 Colgate Drive  position (Name of ematory or other place) W Crematory 3/26	Date 2	HIII MD  Oc. Location - City or Tow  BALTIMORE,	
Dailimore	permit. P Departme Importan any injuri		21. Signature of Funeral Service Licenser  1. LULA (D) (M) (M) (M) (M) (M) (M) (M) (M) (M) (M	22. Name and Address of Facility Col 300MaceAve.Balt	nnellyFi	uneralHome	
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or complications that caused the death period e shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		or respiratory arres	st,	Approximate Interval Between Onset and Death
. DOY 00 YOU,	The law requires that the death certificate be executed site has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical Ex	1 Ves 2 VNo 4 Pregnant at time of death 5	□Ectopic pregnancy □ Other (specify)		23d. Date of deliven	y Day Year
, L	w requires that the death certific been signed by the attending p should be detached for use as	by	9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		acco use contribute to the	
	sicion: The law requ s certificete has been lirector, page 2 shoul	Completed			24a. Was an autopsy performe	prior to com	sy findings available pletion of cause of
V 150	s certific	o Be	25. Was case referred to medical examiner?  1 Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatie	04	n (Check only one)	) ice 6 <b>X</b> Other ( <i>Specify</i> )	HOSDICE
	To the Hospital or Attending Physician: The inwithin 24 hours after death. To the Funeral Director: After this cartificate he completely filled in by the funeral director, page	ation: T	27. Manner of Death 1 ▼Naturat 5 □ Pending 2 □ Accident investigation 2 2 3 Date of Injury (Month, Day Year) 28b. Time (Month, Day Year) Injury	of 28c. Injury at	28d. Describe how		HODI TOL
	itel or Att irs after de rel Directo led in by t	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28.e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Stre City or Town,	eet and Number or Rural I State)	Route Number,
	the Hosp in 24 hou the Fune pletely fil	Medical	29a. Certifier (Check only one)  1 Certifying Physicien: To the best of my knowledge, dea  2 Medicel Examiner: On the basis of examination and/or i  and manner stated.	ith occurred at the time, date and place, nvestigation, in my opinion, death occurr	ed at the time, date	e and place, and due to t	he cause(s)
	with To	2	29b. Signature and title of certifier	29c. License number	290	d. Date signed (Month, Da	iy, Year)
	d		30. Name and address of person who completed cause of death (Item 23a) (Type			Jaju	1
la.	Sta Registr		DR. TARTO MAHMOOD 2300 DULANEY VAI  31. Date filed (Month, Day, Year) 32 Aegistrar's Signature  MAR 2 8 2005	LLEY RD. TIMONIUM,	MD 2109	23	
	, region	1	MARION IN 19				

MARCH 23, 2005

			1- For State of Maryland / Registrar	Department of Health and M Certificate of Death	lental Hygiene	05 10411
			Decedent's Name (First, Middle, Last)		2. Date of Death Month Day	3. Time of Death
	Physic: /Medi		GRACE D. KARL		4 4 4 4 4 4	2005 8 45 A M
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. Cour	nty of Death
			William Hill Monoe Nursing Home	EASTON M	TI	+ LBOT
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last to	birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Year)	Birthplace (State or Foreign Country)
	Director		215-05-8345 10M20F 92		nov 12, 1912	M.S.
	pu 🖈		Usual Residence of Decedent  10a, State 10b, County 10c, City, To	wwn or Location		10d. Inside City Limits
	aryla sho	5				1 Tyes 2 No
	38e-f	ecto		eensTown		
	with t	Funeral Director	10e. Street and Number	10f. Zip Code		of What Country?
	s 23c	rai	737 STAGUEY RD.	21658		
	er de	nu	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I	Rican, etc.)	ace - American Indian, lack, White, etc.
36	rs aft	by F	1 Never Married 2 Married 1 Yes, Give	1 ☐ Yes 2 ☐ No Specify:	Spec	eify: in the
21215-0036	within 72 hours after death with the Maryland ene. than "netural", or items 23e or 28e-f show the Madical Examinar must be notified at	pa		a. Decedent's Usual Occupation	16b Kind of	Business/Industry
15	in 72 n "ne	Completed	(Specify only highest grade completed)	(Give kind of work done during most of working life. DO NOT use retired)	ng	,
212	with iene	E	Elementary/Secondary (0-12) College (1-4or 5+)	Homemaker	tte	me.
	othe	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Maiden Sum	ате)
an	lid be henta ked ked	To B	LeRoy W. Dill SR	ADella	BARTH.	
Maryland	2 should be filed withi and Mental Hygiene. Is marked other than eumatic event, the M	-	19a. Informant's Name/Relationship (Type, Print)	9b. Mailing Address (Street and Number or Rura		m, State, Zip Code)
Σ	rt r		Lois LACHER	737 STAEWELL KD. G	QueensTown N	w 21658
e,	of He fitem		20a. Method of Disposition 20b. Place	of Disposition (Name of D	ate 20c. Location	n - City or Town, State
Baltimore	permit. Pages 1 a Department of Hes Importent: If item any injury or othe		Burial 2 Cremation 3 Removal from State	Reserve Cem 3/30	105 Pait	o. Aw.
alti	permit. Pag Department Importent: I any injury o		21. Signature of Juneral Service Licensee	22. Name and Address of Facility	ella FUNKKAI	HORE CHTO.
m	Depa Impo		Vaul M. Stelle	22. Name and Address of Facility HARTIEY MILLER - STO 1527 HESTERN RD	B4 Hz. Md 2	1434
			23a. Part. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition Braun	em Corebracard	a accept	Onset and Death
	/Medical		resulting in death)  Due to (or as a consequence	e of):	1000000	13.000
	Examiner		Sequentially list conditions b. Orebroom	estella Meseare		Stym
	7 =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	9 of):		0
	nd	Examiner	that initiated events			
0,	e exe tan a urial-		resulting in death) Last Due to (or as a consequence	∋ of):		
8760	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	d			
99	eath certific attending pl	Med	IF FEMALE:			
Вох	ath ce ttend or us	lan/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deat			Date of delivery  Month Day Year
0.	e de the a	Sic	1 ☐ Yes 2 ☒ No 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 Other (specify)		July 1041
P.0	that the de ed by the detached	Phy	Part II. Other significant conditions contributing to death but not resulting	in the underhing eques given in Red I	23a Did tobacco uso co	ntribute to the cause of death?
JS,	ires tha signed I be dei	by	Record 2 new man	in the underlying cause given in Fatti.	1 ☐ Yes 2 🕅 No	3 Probably 4 Dunknown
0	w requir been si should	etec	H. O. Ja	1600		
Sec	e law has b	Completed	109 juspenson with the	and Stole would besen	autopsy	Were autopsy findings available prior to completion of cause of
		Co			performed? 1 ☐ Yes 2 No	death? 1 ☐ Yes 2 ☐ No
Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?  Hospital: Hospital:	26. Place of Death	(Check only one)	
of	this al dii	2	1 Tes 2 KNO 1 Inpatient 2 ER/C		ne 5 Residence 6 0	
	De le	lon	1) Natural 5 ☐ Pending (Month, Day Year)	. Time of lnjury at Work?  M 1 □ Yes 2 □ No	8d. Describe how injury occu	11.60
Division	Attending or death. ector: After by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, to		8f. Location (Street and Nun	aher or Pural Poute Number
N	or A after Direct in by	ertif	4 Homicide determined building, etc. (Specify)	am, street, ractory, onice	City or Town, State)	noer or nural notice Number,
_	To the Hospitel or Attendir within 24 hours after death. To the Funerel Director: Af completely filled in by the fu		29a. Certifier 1 CCertifying Physician: To the best of my knowledge	Je, death occurred at the time, date and place a	nd due to the cause/s) and r	nanner as stated
	24 h 24 h Fur etely	edical	(Check only 2 Medical Examiner: On the basis of examination a one) and manner stated.	and/or investigation, in my opinion, death occurre	d at the time, date and place	e, and due to the cause(s)
	othio oth ompl	Me	29b. Signature and title of pertifier	29c. License number	29d. Date sign	ed (Month, Day, Year)
)	r > F ō		Nellem Haral	JMD DOSTIC-	7/5	25/25
	701		30. Name and address of person who completed cause of death (Item 23a)	7.3	1/6	-/0-
•	1		Live in least ALA COL	1	EASTON MO	21601
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	rent Styll 1	
	Registr	ar	MAR 2 8 2005	and a		

		•	1 - State Registrar	State of Ma	ryland / Dep		Health and M	ental Hygi	-	0 10412
	Physici /Medio Examir	al	Decedent's Name (First, Middle, Last     Joshua Ladeji      Aa. Facility Name (If not institution, give	street and number)			or Location of Death	2. Date of Death Month March 1	7, 2005  4c. County of Dea	
	Funeral Director		IV/ A		(In yrs. last birthday Yrs.	Silver If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birth (Month, Day, March 1	Montgome Year) 9. Bir 3, 2005 Ma	TY thplace (State or Foreign ountry) TYLAND
	he Maryland 28a-f show cuited at	ector	Usual Residence of Decedent  10a. State 10b. County  Maryland  10e. Street and Number		10c. City, Town or L Odenton	ocation		10	og. Citizen of What C	10d. Inside City Limits 1 ☐ Yes 2 🔊 No
20	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural", or Items 23a or 28a-f show apprintury or other traumatic event, the Madical Examinar must be notified at ance.	Completed by Funeral Director	1802 Goldsboroug	12. Was Decedent B Armed Forces? 1  Yes 2 N If Yes, Give Year or Dates:	ever in U.S. 13	21113	Hispanic Origin? (Spe an, Mexican, Puerto Specify:	и	nited Star 14. Race - Am Black, Whi Specify: Bl	tes erican Indian, te, etc.
baitimore, maryianu z iz i 3-0030	ed within 72 hour /giene. er then "natural" t, the Madical Er	Completed t	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) N/A	ucation	(Giv		during most of worki	ng	6b. Kind of Business	Vindustry
llyiaiiu	should be filk and Mental Hy marked oth umatic event	To Be	17. Father's Name (First, Middle, Last)  Kehinde Ladeji  19a. Informant's Name/Relationship (7	ype, Print)	19b. Mai	ling Address (Street	18. Mother's Name Tolu Eli	liot	laiden Sumame)  City or Town, State,	Zip Code)
OIC, Ma	Pages 1 and 2 anent of Health ar nert of Health ar int: If Item 27 is iry or other trau		Tolu Elliot-Moth	Removal from State	20b. Place of Disp cemetery, cre	position (Name of ematory or other pla	ice)	ate 2	n, MD. 211	Town, State
Dall	permit. Pa Departmen Important: eny injury		4 □ Donation 5 □ Other (Specify  21. Signature of Funeral Service Licens	50e		22. Name and Addre	ess of Facility FL	eck Fune	awrel, MD. ral Home, wrel, MD.	Inc.
	Physician /Medical Examiner	er	23a. Part1. Enter the disease, or companies, or heartfallure. List only of immediate Cause (Enal disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	a	the death. Do not elle.  IL prematural a consequence of):		ng, such as cardiac c	or respiratory arre	st.	Approximate Interval Between Onset and Death 4 days
,007.00	icate be executed physician and s the burial-transit	edical Examiner	cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as	a consequence of):					
7.0. DOX	The law requires that the death certificate tte has been signed by the attending phys age 2 should be detached for use as the	Physiclan/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetel death 3	□Ectopic pregnand □ Other (specify) _	Sy		23d. Date of de Month	olivery Day Year
'cn .	w requires that the de been signed by the a should be detached f	þ	Part II. Other significant conditions of	ontributing to death b	ut not resulting in the	underlying cause gr	ven in Part I.			o the cause of death? robably 4 Unknown
אסט ופ	iician: The Iaw re certificate has be rector, page 2 shu	Completed						24a. Was an autopsy perform	led? death? ☑ No 1 ☐ Yes	utopsy findings available completion of cause of s 2 No
-	/siciar s certif directo	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	nt 2 ER/Outpatio	ent 3 DOA Ot	26. Place of Death		nce 6 □Other (Spe	ecify)
Division of Vital necolus,	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification: T	27. Manner of Death    Natural   5   Pending   investigation	28a. Date of Inju (Month, Day		of 28c. Inju	iry at ork? ] Yes 2 No	28d. Describe ho	w injury occurred eet and Number or R	
2	To the Hospital or A within 24 hours after To the Funeral Directompletely filled in by	Medical Cert	29a. Certifier 1 Certifying Ph	ysicien: To the best	of my knowledge, dea	ath occurred at the t	ime, date and place,	and due to the ca	use(s) and manner a ite and place, and du	s stated. e to the cause(s)
	To the To the comple	Me	29b. Signature and title of certifier				se number	1	od. Date signed (Mon	
0			30. Name and address of person who a Andrea Lotze, MD				ver Spring	MTD 20	910	
	St	ate	31. Date filed (Month, Day, Year)	\$2. Registra	ar's Signature	we said	or oprocity	, 1 20	,,,,	

			FOR	epartment of Health and Menta Certificate of Death	al Hygiene
	0		Decedent's Name (First, Middle, Last)		te of Death 3. Time of Death
	Physici	an	Florence M. Lewis		onth Day Year Arch 22, 2005 5:30 P
	/Medio			4b. City, Town, or Location of Death	arch 22, 2005   5:30 P <sup>M</sup>
1	Examir	ner	4a. Facility Name (If not institution, give street and number)		·
			Manor Care Dulaney	Towson	Baltimore
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	day) If Under 1 Year If Under 24 Hrs. 8. Da  Months Days Hours Min.	te of Birth onth, Day, Year)  9. Birthplace (State or Foreign Country)
	Director		212-36-0/59	rs. Fe	eb. 3, 1903 Maryland
	D .		Usual Residence of Decedent		
	how	١.	10a. State 10b. County 10c. City, Town	or Location	10d. Inside City Limits
	Ma Merita	ğ	Maryland N/A Balt	imore	1 MÅYes 2 □ No
	ith the Marylar or 28a-f show	ě	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	With O	by Funeral Director	5219 Anthony Avenue	21206	U.S.A.
	eath	era	11. Marital Status 12. Was Decedent Ever in U.S.		
	er d	S	Armed Forces?	<ol> <li>Was Decedent of Hispanic Origin? (Specify Yolf Yes, specify Cuban, Mexican, Puerto Rican,</li> </ol>	etc.) Black, White, etc.
36	s aff	Y	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ <b>X</b> No Specify:	Specify:
21215-0036	within 72 hours after death with the Maryland ene. than "netural", or itams 23e or 28e-1 show he Medical Examinar must be notified at	D T		Name de alla contra de la contra del contra de la contra del la contra	White
5	72 net	ete	15. Decedent's Education 16a. I (Specify only highest grade completed)	Decedent's Usual Occupation Give kind of work done during most of working	16b. Kind of Business/Industry
7	ithin Ber	du	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired)	
	y dier	Completed	6	Homemaker	Own Home
b	12 should be filed within h and Mental Hygiene. 7 is marked other than " raumetic evant, the Med	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First	Middle, Maiden Surname)
<u>_</u>	fenta fenta rked rked	2	August Henry Rohm	Wilheimin	na M. Ackerman
2	shou man	_		Mailing Address (Street and Number or Rural Rout	e Number, City or Town, State, Zip Code)
Maryland	iges 1 and 2 should be filed within 72 hours after death with the Maryla nt of Health and Mental Hygiene. If Itam 27 is marked other than "netural", or Itams 23s or 28s-1 show or other traumetic evant, the Medical Exammer must be muffled at		Joseph J. Lewis Son 22	07 Dalewood Road Timo	nium, Maryland 21093
- 10	ss 1 and 2 of Health Itam 27 i		20a Method of Disposition 20b. Place of I	Disposition (Name of Date	20c. Location - City or Town, State
Baltimore	Pages nent of I int: if It		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State MOST.	crematory or other place)	
Ξ.	Pa ner ant		` 4 □ Donation 5 □ Other (Specify) Rede	emer Cemetery 3-29-200	5 Baltimore Maryland
ä	permit. Pa Departmer Important any injury once.		21. Simplure of Funeral Service Licensee	22. Name and Address of Facility Ruck	Towson Funeral Home, Inc.
$\mathbf{\omega}$	50 E E 8		Tail a Hogan	1050 York Road Tow	son, Maryland 21204
			23a. Part1. Enter the disease, or complications that caused the death. Do no		ratory arrest. Approximate
			shock, or heart failure. List only one cause on each line.		Interval Between Onset and Death
	Physician .		disease or condition resulting in death)	artery disease	Wyoars.
	/Medical Examiner		Due to (or as a consequence of	):	0
	Lxaiiiiiei		Sequentially list conditions b.		
5		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or kindly)	):	
	uted d ansi	Ē	Cause (Disease of Injury that initiated events c.		- 0
	al-tr	Examiner	resulting in death) Last Due to (or as a consequence of	):	
760	a be executed sicien and burial-transit	call			
687	W	dic	d		
9	leath certifical attending phy I for use as th	Physician/Med	IF FEMALE:		
Box	tenc tenc	an	23b. Was decedent pregnant  23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death	3 ☐ Ectopic pregnancy	23d. Date of delivery  Month Day Year
	dea ne al	SC	in the past 12 poinths?  1   Yes 2   No 9   Unknown	5 Other (specify)	
P.0	t the by th	hy	9 Unknown		
	The law requires that the death cer ate has been signed by the attendir page 2 should be detached for use	y P	Part II. Other significant conditions contributing to death but not resulting in	he underlying cause given in Part I. 23	Be. Did tobacco use contribute to the cause of death?
ds	uires Isign	d b	chronic obstructive pulm	mary disease	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
Records,	w requir been si should	Completed by			12 Mars autorou findings qualible
e	law las	npi	osteoporosis		ta. Was an autopsy findings available prior to completion of cause of death?
<u> </u>	The ate h	Ö	•	10	Yes 2 No 1 Yes 2 No
Vital	ian: rtific tor.	a	25. Was case referred to medical	26. Place of Death (Chec	ck only one)
>	Physician: this certificatal director, partitions	To B	examiner?  1  Yes 2 No  Hospital: 1 Inpatient 2 ER/Outp	patient 3 DOA Other: 4 Nursing Home 5	☐ Residence 6 ☐ Other (Specify)
o	Ph or thi		27. Manner of Death 28a. Date of Injury 28b. Till (Month, Day Year) Inj	ne of 28c. injury at 28d. De	escribe how injury occurred
o	ding P. Afte tune	tlor	1 Natural 5 Pending (Month, Day Year) Inj	ury Work? M 1 ☐ Yes 2 ☐ No	
S	Attending or death.	ca	3 Suicide 6 Could not be and Bloom of Injury. At home for	n, street factory office 28f. Lo	cation (Street and Number or Rural Route Number.
Division	fter Sirec in by	Certification;	4 Homicide determined building, etc. (Specify)		y or Town, State)
	itel Irs a ral (				
	hor une une	cai	29a. Certifier (Check only   Medical Exeminer: On the basis of examination and		
	To the Hospitel or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	one) and manner stated.		
	To t To t	Σ	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
			W + WW	1) 11 11 10 11 10 11	3 23.05
7	1		20. Name and address of person who completed series of death (free 200) T	ima Printl	
K	- 1		30. Name and address of person who completed cause of death (Item 23a) (T	Taracas	~ MA 417-04
			Of State fled (March Day Your)	yore to jours.	V - V - (
	Sta		31. Date filed (Month, Day, Year)  32. Registrar's Signature	1	
	Regist	ar	MAR 2 8 2005 Mayer &	MOBALL .	

	re Medical Ce  Sex 1	nter  rs. last birthday)  88 Yrs.  City, Town or Lo  BALTIMO  16a. Dece (Give life.  TEA  SEID  19b. Maili  1002  b. Place of Dispo cemetery, cre  LLTOP S	4b. City, Town, of Towson Towson If Under 1 Year Months Days  Docation RE  10f. Zip Code 21208  Was Decedent of It If Yes, specify Cubic kind of work done DO NOT use retires. CHER  MAN Ing Address (Street BITTERS) Dosition (Name of matory or other pla	If Under 24 Hrs. Hours Min.  Hispanic Origin? (Span, Mexican, Puerto Specify: Dation during most of work d)  18. Mother's Name LILLIAN and Number or Run	ecify Yes or No-Rican, etc.)  ing  a (First, Middle, Marker, Middle, Marker)  BALTIM	4c. County of D Baltime  yaar  9. E 46  14. Race - A Black, W Specify:  6b. Kind of Busine  EDUCAT laiden Sumame)  O City or Town, State 10RE, MD.	eath ore Birthplace (State or Forel Country) MD  10d. Inside City Limit 1 Tyes 2 Not Country? A. merican Indian, thite, etc. U.S.A. sss/Industry  LSCHANSKY e, Zip Code) 21208
Social Settly Number 219-46-7647  sual Residence of Decedent 10b. County MD BALTI  De. Street and Number 1002 BITTERSWEET  Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced (Specify only highest g. Elementary/Secondary (0-12)  Father's Name (First, Middle, Last SAMUEL 10b. SAMUEL 10b. Method of Disposition 1 Burial 2 Coremation 3 4 Donation 5 Other (Specify only highest g. Samuel 10b. Method of Disposition 1 Burial 2 Coremation 3 4 Donation 5 Other (Specify only highest g. Samuel 10b. Method of Disposition 1 Signature of Juneral Service Lice	Sex 1 M 2 S F 7. Age (In y g 1 M 2 S F 1 M 2 S	City, Town or Lot BALTIMO  16a. Dece (Give life. TEA  SEID 19b. Maili 1002  b. Place of Dispo cemetery, cre.	If Under 1 Year Months Days  ocation  RE  10f. Zip Code 21208  Was Decedent of It Yes, specify Cubit If Yes, specify Cubit It Yes 2 No  odent's Usual Occup kind of work done DO NOT use retires  CHER  MAN  Ing Address (Street BITTERS)  osition (Name of matory or other plan  matory or other plan	If Under 24 Hrs. Hours Min.  Hispanic Origin? (Span, Mexican, Puerto Specify: Dation during most of work d)  18. Mother's Name LILLIAN and Number or Run	ecity Yes or No- Rican, etc.)  ing  1  a (First, Middle, M  al Route Number,  BALTIM	g. Citizen of What U.S.  14. Race - Ai Black, W Specify:  6b. Kind of Busine  EDUCAT laiden Sumame)  0  City or Town, State 10RE, MD.	Birthplace (State or Forei MD)  10d. Inside City Limi 1 Yes 2 No Country?  A. merican Indian, thite, etc. U.S.A. ss/Industry  LSCHANSKY a, Zip Code) 21208
219-46-7647  Sual Residence of Decedent  Da. State  MD  BALTI  De. Street and Number  1002 BITTERSWEET  Marital Status  1 Never Married  15. Decedent's E (Specify only highest g.  Elementary/Secondary (0-12)  T. Father's Name (First, Middle, Last  SAMUEL  9a. Informant's Name/Relationship  VINCENT LOMBARDO  Da. Method of Disposition  1 Burial 2 Coremation 3  4 Donation 5 Other (Special Signature of Funeral Service Lice	MORE  10c.  MORE  10c.  MORE  12. Was Decedent Ever in Armed Forces? 1	City, Town or Lot BALTIMO  16a. Dece Give life. TEA  SEID 19b. Maili 1002 b. Place of Dispo	Months Days  Decation  RE  10f. Zip Code 21208  Was Decedent of Introduced the Second Code of Introduced the Second Code of Introduced the Second Code of Introduced the Second Code of Introduced the Second Code of Introduced the Second Code of Introduced the Second Code of Introduced the In	Hours Min.  Hispanic Origin? (Span, Mexican, Puerto Specify: Dation during most of work d)  18. Mother's Name LILLIAN and Number or Run	ecity Yes or No- Rican, etc.)  ing  1  a (First, Middle, M  al Route Number,  BALTIM	g. Citizen of What U.S.  14. Race - A. Black, W Specify:  6b. Kind of Busine  EDUCAT laiden Sumame)  O City or Town, State 10RE, MD.	MD  10d. Inside City Liming 1 Tyes 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
A. State MD BALTI  De. Street and Number  1002 BITTERSWEET  Marital Status  1 Never Married 22 Married  3 Widowed 4 Divorced  15. Decedent's E (Specify only highest g.  Elementary/Secondary (0-12)  7. Father's Name (First, Middle, Last  SAMUEL  9a. Informant's Name/Relationship  VINCENT LOMBARDO  10a. Method of Disposition  1 Burial 2 Dicremation 3 4 Donation 5 Other (Specifical Control of Con	MORE  COURT  12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 ₺ No If Yes, Give Year or Dates:  Education rade completed)  College (1-4-or 5+) 5+  it)  (Type, Print)  / HUSBAND  Removal from State infy)	BALTIMO  16a. Dece (Give life).  TEA  SEID  19b. Maili  1002 b. Place of Disponderry, cre.  ELLTOP S	PRE  10f. Zip Code  21208  Was Decedent of Inference of I	Specify:  pation during most of work o	ecify Yes or No-Rican, etc.)  ing  a (First, Middle, Marker, Middle, Marker)  BALTIM	U.S.  14. Race - Ai Black, W Specify:  6b. Kind of Busine  EDUCAT laiden Sumame)  O City or Town, State 10RE, MD.	Country?  A.  merican Indian, hite, etc.  U.S.A.  ss/Industry  ION  LSCHANSKY  e, Zip Code)  21208
De. Street and Number  1002 BITTERSWEET  Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  15. Decedent's E (Specify only highest given the state of the state	COURT  12. Was Decedent Ever in Armed Forcas? 1 [] Yes 2 N No If Yes, Give Year or Dates:  Education rade completed)  College (1-4or 5+) 5+  (Type, Print) 1	16a. Dece (Give life.  TEA  SEID 19b. Maili 1002 b. Place of Disponsion of the completery, cree ELLTOP S	as Decedent of Hif Yes, specify Cub- Hif Yes, specify Cub- UYes 2 No Indeed to the Yes of the Yes	Specify:  pation during most of work o	ecify Yes or No-Rican, etc.)  ing  a (First, Middle, Marker, Middle, Marker)  BALTIM	U.S.  14. Race - Ai Black, W Specify:  6b. Kind of Busine  EDUCAT laiden Sumame)  O City or Town, State 10RE, MD.	Country?  A. merican Indian, hite, etc.  U.S.A. ss/Industry  ION  LSCHANSKY e, Zip Code) 21208
1002 BITTERSWEET  Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  15. Decedent's E (Specify only highest g.  Elementary/Secondary (0-12)  7. Father's Name (First, Middle, Lass  SAMUEL  9a. Informant's Name/Relationship  VINCENT LOMBARDO  1 Burial 2 Cremation 3  4 Donation 5 Other (Special Signature of Juneral Service Lice	12. Was Decedent Ever in Armed Forces?  1	16a. Dece (Give life.) TEA  SEID 19b. Maili 1002 b. Place of Disponentary, cre.	21208  Was Decedent of Ir If Yes, specify Cubir If Yes, specify Cubir I Yes 2 No Not Not Not Not Not Not Not Not Not	Specify:  pation during most of work o	ecify Yes or No-Rican, etc.)  ing  a (First, Middle, Marker, Middle, Marker)  BALTIM	U.S.  14. Race - Ai Black, W Specify:  6b. Kind of Busine  EDUCAT laiden Sumame)  O City or Town, State 10RE, MD.	A. merican Indian, Thite, etc. U.S.A. ss/Industry ION LSCHANSKY e, Zip Code) 21208
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(Specify only highest g. Elementary/Secondary (0-12)  7. Father's Name (First, Middle, Las SAMUEL  9a. Informant's Name/Relationship  VINCENT LOMBARDO  2a. Method of Disposition  1	College (1-4or 5+) 5+  (Type, Print)  O / HUSBAND  Removal from State HI	SEID 19b. Maili 1002 b. Place of Dispondemetery, cre-	CHER  MAN  Ing Address (Street BITTERS)  Disting (Name of matory or other plan  The Control of the plan  MAN  BITTERS  The Control of the plan  Th	18. Mother's Name  LILLIAN  and Number or Rura  NEET COURT	a (First, Middle, M al Route Number, BALTIM	EDUCAT laiden Sumame)  O City or Town, State	LSCHANSKY e, Zip Code) 21208
SAMUEL  9a. Informant's Name/Relationship  VINCENT LOMBARDO  0a. Method of Disposition  1	(Type, Print)  (Type,	SEID 19b. Maili 1002 b. Place of Dispo	MAN Ing Address (Street BITTERSW Disting (Name of matory or other pla	18. Mother's Name  LILLIAN  and Number or Rura  NEET COURT	al Route Number, BALTIM	laiden Sumame)  O  City or Town, State  10RE, MD.	LSCHANSKY e, Zip Code) 21208
SAMUEL  9a. Informant's Name/Relationship  VINCENT LOMBARDO  0a. Method of Disposition  1	(Type, Print)  O / HUSBAND  □Removal from State iffy)	SEID 19b. Maili 1002 b. Place of Dispondemetery, cre. ELLTOP S	MAN ing Address (Street BITTERSV position (Name of matory or other pla	LILLIAN and Number or Rura NEET COURT	al Route Number, BALTIM	laiden Sumame)  O  City or Town, State  10RE, MD.	LSCHANSKY e, Zip Code) 21208
9a. Informant's Name/Relationship VINCENT LOMBARDO Da. Method of Disposition 1	O / HUSBAND    Compared to the property of the	19b. Maili 1002 b. Place of Disport cometery, creations LLTOP S	ng Address (Street BITTERSV osition (Name of matory or other pla	and Number or Rura NEET COURT	BALTIM	City or Town, State	e, <i>Zip Code)</i> 21208
VINCENT LOMBARDO  Da. Method of Disposition  1	O / HUSBAND    Compared to the property of the	1002 b. Place of Dispo cemetery, cre LLTOP S	BITTERSV osition (Name of matory or other pla	WEET COURT	BALTIM	MORE, MD.	21208
1 Burial 2 Gremation 3 4 Donation 5 Other (Special Signature of Buneral Service Lice	□Removal from State HI	cemetery, cre LLTOP S	matory or other pla	ce)	Onto 0	On Location - City	
* 4 □ Donation 5 □ Other (Special Signature of Juneral Service Lice	ify) HI		EDVICE CO		18		or Town, State
Notes /	ensee -			ORP. 03/25	the second secon		
3a. Part1. Enter the disease, or cor	-/.			ess of Facility SOL			., INC.
isease or condition esulting in death)  equentially list conditions, any, leading to immediate ause. Enter Underlying lause (Disease or injury lat initiated events esulting in death) Last	Due to (or as a con-	(IC LY	МРНО СТ	TIC L	EVKEH11	1	12 HR
FEMALE: 3b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 M No 9 □ Unknown	1 Live birth 2 F	etal death 3[		у		23d. Date of o	delivery Day Year
•		resulting in the u	underlying cause giv	ven in Part I.	23e. Did toba	acco use contribute	to the cause of death?
VENOUS TI	UNOMBOST)				-		Probably 4 ☐Unkno
					autopsy perform	prior t death No 1 □ Y	
5. Was case referred to medical examiner?  1 \( \sum \) Yes \( 2 \sum \) Yo	Hospital:	2 ☐ ER/Outpatie	nt 3 DOA Oth				pecify)
2 Accident	28a. ate of Injury (Month, Day Year	28b. Time of Injury	Wor	ry at rk?			
	d 286. Place of injury - F	kt home, farm, st ecify)	reet, factory, office				Rural Route Number,
9a. Certifier (Check only one)  Certifying F 2 Medical Example 1	Physician: To the best of my aminer: On the basis of exam and manner stated.	knowledge, deat nination and/or in	th occurred at the timestigation, in my o	me, date and place, opinion, death occurr	and due to the cat ed at the time, dat	use(s) and manner te and place, and d	as stated. lue to the cause(s)
9b. Signature and title of certifier.  T-	_		29c. Licens	2773 o	29	d. Date signed (Mo	onth, Day, Year)
3	FEMALE: b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Wo 9 □ Unknown  III. Other significant conditions  Was case referred to medical examiner? 1 □ Yes 2 □ Wo  Manner of Death 1 Natural 5 □ Pending investigati 3 □ Suicide 6 □ Could not determine  Da. Certifier (Check only one)  b. Signature and title of certifier.	Due to (or as a conditions, by teaun got on modified use. Enter Underlying use (Disease or injury at initiated events sulting in death) Last	Enter Undertying use (Disease or injury at initiated events sulting in death) Last    Due to (or as a consequence of):   Due to (or as a consequence of):	Enter Underlying use. Enter Underlying use (Disease or injury at indiated events suiting in death) Last    Due to (or as a consequence of):	Color   State   Stat	Second Companies   Continue   C	Due to (or as a consequence of):  d.    Due to (or as a consequence of):   Due to (or as a consequence of person on the total on the or action of the total on the or action of the total on the or action of the total on the or

			For State Registrar	State of Mar		artment of H			iene	10115
	Physici	an	1. Decedent's Name (First, Middle, Last) EDITH ESTELLE	MILTTALTY				2. Date of Deat Month MARCH	Day Year 25 2005	3. Time of Peath
	/Medic		4a. Facility Name (If not institution, give s			4b. City, Town, or	Location of Deal		4c. County of Death	10:50P M
	Examin	er	FREDERICK MEMO		PITAL	FREDER	RICK		FREDERICE	X
	Funeral		5. Social Security Number 6. Sex		In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		Year) 9. Birthp	lace (State or Foreign
	Director		216-80-8004 Usual Residence of Decedent	M 2 💢 F	90 Yrs.			Dec. 20,	1914 Mary	land
	/tand		10a. State 10b. County	1	0c. City, Town or Lo	ocation			1	0d. Inside City Limits
	a-f sh	to	Maryland Frederic	k	Adamstov	m				1 ☐ Yes 2 🛣 No
	with the	Funeral Director	10e. Street and Number 3200 Baker Circl	o - A124		10f. Zip Code		10	0g. Citizen of What Cour	ntry?
	s 23g	erai		12. Was Decedent Eve	er in U.S. 13	2171		Specify Yes or No-	U.S.A.	an Indian.
336	72 hours after death with the Maryland "naturel", or Items 23a or 28a-f show calcul Esserither uses be notified as	by Fun	1 Never Married 2 Married  3 Widowed 4 Divorced	Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	Specify:	to Rican, etc.)	Black, White, Specify: Whi	etc.
9-0	72 hou		15. Decedent's Educ (Specify only highest grade	cation	16a. Dece	dent's Usual Occupa	ation	orkina	16b. Kind of Business/Ind	
21215-0036	d within 7 giene. ir then "r	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done of DO NOT use retired		, , , , , , , , , , , , , , , , , , ,	Orana II ama	
7			17. Father's Name (First, Middle, Last)	1		Homemaker		me (First, Middle, M	Own Home	
land	o d a b	o Be	James M. Purdu	m			Emm		vis	
Maryland	s 1 and 2 should be f Health and Mental Item 27 Is marked other treumatic ev	۲	19a. Informant's Name/Relationship (Type						City or Town, State, Zip	
	s 1 and of Health Item 27 other tr		James Kenneth Mul	linix - So	20b. Place of Dispo	29 Holbert	on Lane		20c. Location - City or To	
Baltimore,	Pages hent of		1 □ Burial 2 □ Cremation 3 □ R  '4 □ Donation 5 □ Other (Specify)	emoval from State	cemetery, cre	matory or other place			5 Damascus,	
Balti	permit. Pages Department of I Importent: If it any injury or o		21. Signature of Funeral Service Ucense	90					neral Home , Maryland	20872
Г	- 0		23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused the cause on each line.	e death. Do not en	ter the mode of dying	g, such as cardia	c or respiratory arre	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	l	Myc	cardia	l 2n	facti	on	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):					
l.	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):					
	sician and burial-transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last	.  Due to (or as a o	consequence of):					
8760,	ate be ex nysician he buria	ical E								
9	tificate ng phys as the									
.O. Box	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	3c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tir 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ery Day Year
<u>α</u>	es De	by	Part II. Other significant conditions con	itributing to death but	not resulting in the u	inderlying cause give	en in Part I.	23e. Did tob	pacco use contribute to the	,
Records,	9 2 9	Completed						24a. Was as autops perform	y prior to cor death?	psy findings available mpletion of cause of
Vital	slcien: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?				26. Place of De	eath (Check only on		
of V	Physicien: this certific ral director,	은	1 ☐ Yes 2 No	lospital: 1 Inpatient			4   Nursing		nce 6 Other (Specify	y)
		ion:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day )	/ear) 28b. Time (	Work	vat ⟨? Yes 2 □ No	28d. Describe ho	w injury occurred	
Division	or Attendatifier deat	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	- At home, farm, st (Specify)			28f. Location (Sti City or Town	reet and Number or Rura n, State)	i Route Number,
_	Hospite 4 hours Funerel	edical C			xamination and/or in				tuse(s) and manner as state and place, and due to	
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and little of certifier			29c. License	number	29	9d. Date signed (Month,	Day, Year)
	4		Sout	$\sim$	MD	D.	5837	1	3-27-	05
	0		30. Name and address of person the co	mpleted cause of dea	th (Item 23a) (Type	Print) TOLL He	ruse A	Tre, F.	3-27- uderiel	102170
	Sta		31. Date filed (Month, Day, Year)	39. Registrar	s Signature	All I		,	/	,
	Regist	rair	MAR 2 8 2005	House	15 14					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item#18, perFit C845, 7/15/05 TT State of Maryland? Department of Health and Mental Hygiene Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 23, 3:00 P Genevieve E. Maxwell March 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Cecil Conowingo 200 Weaver Meadow Road If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Mar 14,1910 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign 6. Sex **Funeral** Months 1□M 2√2F MAryland 212-30-3998 95 Director Usuel Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Items 23s or 28s-1 show any injury or other traumatic event, I'm Madical Examinist must be notified at once. MD Cecil Conowingo 1 Yes 2 XNo Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 200 Weaver Meadow Road 21918 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Marned 21215-0036 1 ☐ Yes 2🔀 No Specify: Specify: White 3 Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 17. Father's Name (First, Middle Last)

Jesse James Brent, Jr.

Jesse Brent Jr. Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname Be Ella Mae Garfield Davis 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 194 Weaver Meadow Road Conowingo MD NormaLynn Franklin/Daughtes 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State MeadowridgeCemetery 3/28/05 Baltimore MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility ConnellyFuneralHomeofEssex 21. Signature of Funeral Service Licensee 300 Mace Ave. Baltimore MD 21221 23a. Part1. Enter the disease, or conditions that caused the death shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death onot enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner AI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of). Box 68760 the attending physician Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 9 ☐ Unknown 4☐Pregnant at time of death 5 Other (specify) Ö detached 9 Unknown signed by d م Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? certificate has 1 Yes or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Yes 20 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Natural Injury 5 Pending s after death.
I Diractor: At 1 ☐ Yes 2 ☐ No investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Momicide within 24 hours a To the Funerel ( the Hospitel 29a. Certifier Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month), Day, Year) 29b. Signature and title of certifuer D69768 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , Rsing Sun, MS Jokhadar, 281 E. Main 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2 8 2005

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** March 26, 2005 9:25 Muller Linda Lou /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a, Facility Name (If not institution, give street and number) Examiner Westminster Nursing & Conval. Cntr Westminster Carrol1 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex **Funeral** Months 1 ☐ M 2 🔀 F Director 216-56-6353 56 27, 1949 | Maryland Usual Residence of Decedent the Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a. State show item 27 is marked other than "naturel", or items 23a or 28e-f show other treumatic event, the Madical Examilian in using the modified at 1 ☐ Yes 2 No Director Carrol1 Westminster 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 120 A Pennsylvania Avenue 21157 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ②No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. Is marked other than "naturel", or Itel 1 Never Married 2 Narried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Own Home Homemaker permit. Pages 1 and 2 should be file.
Department of Health and Mental Hygi
Importent: If item 27 is marked any injury or other the any injury or other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Dorothy Viola Howard Webster Murray, Sr. Barnes ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 512 South Queen Street Littlestown, PA 17340 Amanda Marie Ball Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation Ser. 3/31/05 Hampstead, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road Eline Funeral Home Reisterstown, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic Physician /Medical Examiner Sphagia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine certificate be executed use as the burial-transit Hypoalbumine
Due to (or as a consequence of): attending physicien Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No for 5 ☐ Other (specify) 4☐Pregnant at time of death P.O. I þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Tes 2 No 3 Probably 4 Unknown sorders Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 2 NO funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Narsing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 1 ☐ MG 1 Inpatient 2 ER/Outpatient 3 DOA 2 his 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Hospitel or Attending Pl 24 hours after death. 9 Funerel Director; After th 27. Manner of Death Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 24 hours a 1 Critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signa 0054218 Malcolm din, Westminuty MD 21157 who completed cause of death (Item 23a) (Type, Print) Kaneus. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

			For State Ragistrar	State of Maryla			nt of Health a te of Death	and Me	-	iene2 ()	05	10418
1			1. Decedent's Name (First, Middle, Las	t)				2.	Date of Deat Month	th Day	Yeer	3. Time of Death
	Physicia /Medic		GENEVIEVE	LEE	MARS	Н		М	arch	19,	2005	9:55 A <sup>M</sup>
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. Cit	, Town, or Location of	of Death		4c. Count	ty of Deeth	
d			84 Somers Cove Ap				Crisfie				Some	
	Funeral		Social Security Number     6. Se	DM aNE	s. last birthday)	Month:	er 1 Year If Under 2 Days Hours	Min. 8.	Date of Birth (Month, Day,	Year)		place (State or Foreign htry)
2	Director		214-34-6158	7.	3 Yrs.			De	cember	7, 19	31 Ma	ryland
	and *	}	Usual Residence of Decedent  10a, State 10b, County	10c. (	City, Town or Lo	ocation					1	Od. Inside City Limits
	eho	5			•		a : c:	2.2				XXYes 2 □ No
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	s 23	Funeral	84 Somers Cove Ap	Dartments  12. Was Decedent Ever in	11 5 13	Was Don	21817	nin? (Specif	v Yes or No-	14 Ra	USA ace - Americ	can Indian
	ltem Der de	un.	11. Marital Status	Armed Forces?	0.5.	If Yes, sp	edent of Hispanic Orig ecify Cuban, Mexican	, Puerto Ric	an, etc.)		ack, White,	
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ᅙ	be filed tal Hygie d other	Be C	17. Father's Name (First, Middle, Last)		•		18. Mothe	er's Name (F	First, Middle, I	Maiden Suma	ame)	
Maryland	V a b	To B	Clyde A. Evans				Clar	a L.	Shehee			
ary	de la la		19a. Informant's Name/Relationship (7	ype, Print)	19b. Maili	ing Addre	ss (Street and Numbe	or or Rural R	Route Number	, City or Tow	n, State, Zip	Code)
	and 2 lealth a m 27 h		Winnie L. Bloxom	(Daughter)	4731	Por	lar Street	- Cr	isfiel	d, Mar	yland	21817
Baltimore,			20a. Method of Disposition	20b	. Place of Dispe	osition (N	ame of other place)	Date	9	20c. Location	- City or To	own, State
Ë	Pages nent of h ant: If its arry or of		1 ☑ Burial 2 ☐ Cremation 3 ☐  1 ☑ Donation 5 ☐ Other (Specify		nnvridae	Memo	rial Park 3	3/23/0	5	Crisfi	eld.	Maryland
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Ö	Depa Impo eny l		Mary Beth Bra	dshaw-Pruitt	wll		W. Main S				. MD	21817 _
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9	The law requires that the death certificat 11e has been signed by the attending phy 2ge 2 should be detached for use as th	Physician/Med	IF FEMALE:									
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Ö	law r as be	pie							24a. Was a autops	SV V	prior to co	opsy findings available impletion of cause of
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of <	hysic I dire	2	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatie	ent 3		irsing Home	5 X Resid	ence 6 🗆 O	ther (Specia	(y)
0 =		:uo	27. Manner of Death  1 ■ Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of	28c. Injury at Work?		d. Describe h	ow injury occu	urred	
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Division	l or Attend after death Director: /	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury · At building, etc. (Spe	t home, farm, st cify)	treet, fact	ory, office	281	I. Location (S City or Town		nber or Rur	al Route Number,
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	To the h within 24 To the F complete	fed	one)	and manner stated.								
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	1	/		r	· -		D6015715	)		3	22.05	
1	10		30. Name and address of person who		-							
			26423 BURTON AUE				Willia	am Gil	1, M.D	•		
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ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last). Month Year **Physician** Rou 2:15 005 ward Narch /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner HomorE 8. Date of Birth (Month, Day, Year)
July 14, 1908 Birthplace (State or Foreign Country)
 MD 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Social Security Number
 217–01–0855 Sex 1**X**1M 2□F **Funeral** Hours Davs 96 Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State item 27 is marked other than "neturel", or items 23s or 28e-f show other treumstic event. It a Modical Examinar must be notified at 1 XYes 2 No Baltimore Director MD. N/A 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number filed within 72 hours after deeth with I Hygiene. 21213 3738 Bonview Avenue USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1★1Yes 2 □ No If Yes, Give Year or Dates: Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: Specify: White 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Fuel Oil Company 8 years Serviceman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be should be fi Julia E. Cavey Joseph Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 sl ment of Heelth an ent: If item 27 la r 2340 Searles Road, Dundalk, MD. 21222 Leroy W. Miller son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State March 29. permit. Pages
Department of
Importent: If it
any injury or o 1 Burial 2 Cremation 3 Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Crownsville VA Cemetery 2005 Crownsville, MD <sup>22. Name and Address of Facility</sup> Home Of Dundalk, P.A. 7110 Sollers Foint Road, Dundalk, Md. 21222 21. Signature of Funeral Service Licensee 23a. Parl 1. Enter the disease of complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Approximate Interval Between Onset and Death, Immediate Cause (Final Physician STNKE month disease or condition resulting in death) /Medical Due to for as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Caus 3 (Decase of July) that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): attending physicien Physician/Medical the for use as IF FEMALE: 23c. If yes, outcome of pregnancy
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DHMH 17 Rev 1/2001

Registrar

2 8 2005

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

			1 - For State Registrar	State of M	Maryland		artment rtificate			and Mo	F	Reg. No	005	101.20
ı	Physici		Decedent's Name (First, Middle, Last		BRYAN	MEAR	S				2. Date of Dea Month MARCH	Day	2005	7:55 P. M
}	/Medic Examir		4a. Fecility Name (If not institution, give		•				Location o	I Death			ounty of Deat	
	Funeral		HARFORD MEMORIAL  5. Social Security Number 6. Se		AL Age (In yrs. Ia	ast birthday)	If Under	1 Year	DE G	24 Hrs.	8. Date of Birt	h	HARFO 9. Birt	KU hplace (State or Foreign untry)
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	r death	ınera	11. Marital Status	12. Was Deceder Armed Force	s?	S. 13.	Was Decede	ent of His	spanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)	- 14	I. Race - Ame Black, White	
39	72 hours after death with the Maryland natural', or items 23s or 28s-1 show diesi Eventiner must be notified at	by Funeral Director	1 Never Married 2/10/Married 3 Widowed 4 Divorced	1 □ Yes ★ If Yes, Give Year or Date:	(INo s:		1□Yes 2	<b>X</b> X/No	Specify:			s	Specify:	WHITE
2-0	72 hou natura	eted	15. Decedent's Edi (Specify only highest grad	ucation le completed)		(Give	dent's Usual kind of worl	k done d	uring most	of working	ng		of Business/	•
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Baltimore, Maryland 21215-0036	<b>₽ 5 5 ●</b>	To Be C	17. Father's Name (First, Middle, Last) JENN	NGS ME	EARS					r's Name VELY	(First, Middle, N HAL	Maiden S LAND		
Mary	nd 2 should lith and Mer 27 le marke r treumatic		19a. Informant's Name/Relationship (TANDREA MEARS (V	ype, Print) VIFE)			-				FALLST (			D, 21047
ore,	permit. Pages 1 an Department of Heal Importent: If item 2 any injury or other once.		20a. Method of Disposition 1 □/Burial 2 □ Cremation 3 □	Removal from Sta	. Ce	ace of Dispo	natory or ot	her place	9)		ate		ation - City or	
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Ba	Depar Impo		P. J. Kun			R	UCK T	OWSO	N FUN	IERAL	HOME,	INC.		N,MD.21204
	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	ne cause on pact	ed the death in line.	) :	er the mode	1 -		cardiac oi	r respiratory ar	rest,		Approximate Interval Between Onset and Death
	/Medical Examiner	٦.	resulting in death)  Sequentially list conditions,	b	as a consequal as a consequence as a consequence as a consequence as a consequence as a consequal as a consequal as a consequence as a consequence as a consequence as a consequence as a	ant	ey D	V						
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9	death certificate e attending phys d for use as the	/Medi	IF FEMALE:	23c. If yes, outcor	ne of pregnar	nev						22	d Data of dali	
.O. Box		Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 Mono 9 ☐ Unknown	1 Live birth	2 Fetal tat time of de	death 3	Ectopic pre Other (spe					- 23	d. Date of deli Month	Day Year
<u>а</u>	sign Sign The	þ	Part II. Other significant conditions co	ntributing to death	n but not resu	Iting in the u	nderlying ca	ause give	n in Part I.		_	obacco use /es 2 🗆		the cause of death?
Vital Records,	The law ate has b page 2 s	Completed									24a. Was autop perfor	sy		topsy findings available completion of cause of 2 No
Vita	ilcian: certific rector,	Be	25. Was case referred to medical examiner?	Hospital:	VM	-5.0		Othe	ir.		(Check only o			
of		n; To	27. Manner of Death	28a. Date of I		ER/Outpatier 28b. Time of Injury	-	Bc. Injury Work	at		ne 5 Resid			cify)
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Ω	al or Attends after death	Certification;	4 Homicide determined	28e. Place of building,	etc. (Specify		eet, ractory,	, onice			City or Tow	vn, State)	rvamber or ric	nar noute vumber,
	To the Hospital or Attending within 24 hours after death. To the Funerel Director; After completely filled in by the fune	edical (	29a. Certifier (Check only one) 2 Medical Exam	rsician: To the be iner: On the basis and manner	s of examinati									
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	129		30. Name and address of person who co	S M	, 9	>chill	Print)	Ed	Hi	wtl	balley	M	210	3D
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	1 - For State Registrar		State of Ma	arytanu / t		nent of r icate of		ivientai		en en	F <sup></sup> 1 0 1 0	
	Registrar  1. Decedent's Name (Firs	t Middle Last)			Certin	cate of	Dealli	2. Date	Reg. N	10.0	3 Time of Death	+
Physician /Medical	·Talan	A M	c Eac	herr	\ , , ,	Jr.		, Mont	ich "	16 20	DS 11:04PM	Л
Examiner	A. Carlle Man . Of and le	nstitution, give s				. City, Town, o	r Location of De		1 .	c. County of D	more_	
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Director	219 52 77 Usual Residence of Dece	//	M 2□F	55	Yrs. Me	onths Days	Hours M		n, Day, Yea • 6 <b>,</b> 1 9		IRGINIA	
aryland show	10a. State 10b.	County		10c. City, Tow	n or Location	on					10d. Inside City Limits	
ith the Marylar or 28a-f show se notified at	MD.	BALTIM	ORE	BA.	LTIMO				100		1 ☐ Yes 2 No	_
23a or 2	3506 WILD	CHERR	Y ROAD		,	0f. Zip Code 212	44			itizen of What		
dea	11. Marital Status	1	Was Decedent E Armed Forces?	v•r968	13. Was	Decedent of H	lisp <i>a</i> nic Origin? an, Mexican, Pu	(Specify Yes	or No-		merican Indian, /hite, etc.	
ire, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23e or 28e-f show other traumatic event, the Medical Examiner must be notified at To Be Completed by Funeral Director	1 ☐ Never Married 2 3 ☐ Widowed 4 ☐ C	Married	1 LYes 2 N If Yes, Give Year or Dates:	969	ŀ	Yes 2 No	Specify:	one moun, on	.,	Specify:	BLACK	
21215-00 ed within 72 hou ygjene. Instithen "nature instithen "title wedical Et. The wedical Et.	15. C	Decedent's Educ ly highest grade	ation completed)	16 <i>a</i>	. Decedent	s Usual Occup	ation during most of v	vorkina	16b.	Kind of Busine	ss/industry	
21.0	Elementary/Secondary		College (1-4or 5	+)	life. DQ l	VOT use retire	d)	, , , , , , , , , , , , , , , , , , ,		EMENT	FACTORY	
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Maryland 21215-0036 d 2 should be filed within 72 hours alt in and Mantal Hygiene. T? is marked other than "natural", or traumatic event, the Medical Exami	19a. Informant's Name/R						and Number or		lumber, City	or Town, Stat	e, <i>Zip Cod</i> e)	
Baltimore, Mapernit. Pages 1 and 2: Department of Health at Important: If item 27 is any injury or other trauger.	20a. Method of Dispositio		RETIN (M	20b. Place o	f Dispositio	n (Name of	CHERRY	Date	PALT 20c.	O MD Location - City	or Town, State	
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Baltimore, permit. Pages 1 ar Department of Hea mportant: If item my njury or other page.	21. Signature of Funeral		S T. GW	YNN	T227/Na	me@nd Addre						_
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	23a. Part . Enter the disc shock, or heart failu	ease, or compile	ations that caused	the death. Do	not enter th	e mode of dyir	ng, such as card	liac or respirat	ory arrest,	DALLU.	Approximate Interval Between	
Pnysician	Immediate Cause (Final	ire. List only of	Va in	o.	01		illati				Onset and Death	) (
/Medical	disease or condition resulting in death)	a.	Due to (or as a	consequence	of):				<u> </u>		riruite	. >
Examiner	Comments the link and distance	. h	Athe	VOSCL	ert	Tic	Hea	1	Dis	ease	Years	,
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Box eath cert attendin for use	23b. Was decedent pregr in the past 12 month	nant	1 Live birth  4 Pregnant at	2 Fetal death		opic pregnancy ner (specify)	/		- 1	23d. Date of Month	Day Year	
, P.O. Box 68 that the death certificat ed by the attending phy detached for use as th	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		9□ Unknown	ume or death	3 🗆 🔾 (1	iei (specily)						
s, P.O. Box 68 es that the death certifica gned by the attending ph be detached for use as if by Physician/Medi	Part II. Other significant	conditions con	tributing to death bu	ıt not resulting i	n the under	ying cause giv	en in Part I.	23e.	Did tobacco	use contribute	to the cause of death?	
rds quires an sign uld be	<u> </u>							_	1 🗌 Yes	2□No 3□	Probably 4 Denknown	3
aw reas bee									Was an autopsy	24b. Were	autopsy findings available to completion of cause of	е
I Record  The law requir cate has been si page 2 should Completed								101	performed?	death	1?	
/ital	25. Was case referred to examiner?	medical					26. Place of D	eath (Check				
hysic his ce il dired	1 ☑ fes 2 ☐ No	H	ospital: 1 - Inpatie	nt 2 HERVOL	utpatient 3	□ DOA Oth	er: 4 🗆 Nursing	Home 5□	Residence	6 □Other (S	pecify)	
n o n o ng Pri		Pending	28a. Date of Injur (Month, Day	Year) 28b.	Time of injury	28c. Injur Wor	y at k?	28d. Desc	ribe how inj	ury occurred		
ISIO Mtandil death. ctor: A y the fu	2 Accident 3 Suicide 6	investigation Could not be					Yes 2 □ No					
Division of Vital Records, tal or attanding Physician: The law requires the state death.  al Director: After this certificate has been signed in by the funeral director, page 2 should be certification; To Be Completed by	4 Homicide	determined	28e. Place of Inju building, etc	ry - At home, fa . (Specify)	arm, street,	factory, office			ion (Street a or Town, Sta		Rural Route Number,	
		Certifying Phys Medical Examin	ician: To the best of er: On the basis of	examination an	e, death occ	curred at the tir	me, date and pla pinion, death or	ace, and due to	the cause( ime, date a	s) and manner nd place, and o	as stated. due to the cause(s)	
tha Hosp thin 24 hou tha Funal mpletely fil	one) 29b. Signature and title o		and manner sta	ted.		29c. Licens					onth, Day, Year)	
To wit	Zoo. Signature and title o	180	111				6418				6 2005	
<i>E</i> :	30. Name and address of	person who con	npleted cause of de	eath (Item 23a)	(Type, Prin	)				-0.001		
5+1	K. Tonya A	1	MD 541	010	Cou	HRO	ad, Ba	Himo	ve M	Dal	133.	
State	31. Date filed (Month, Da	y, Year)	32 Registra	r's Signature			,					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death PM Month **Physician** 3:58 March 25, 2005 James F. Mood /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Catonsville Charlestown Care Center If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country)
 PA 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1**X**3 M 2 □ F Yrs. Director <u> 160-03-9145</u> Sept. 16, 1910 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits Show 10a. State 10b. County 27 is marked othar than "natural", or Itams 23a or 28e-f shov traumatic avent, Ita Medical Exercit or insist ke inclined at 1 Yes 2 No MD Catonsville Baltimore Director 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 719 Maiden Choice Lane Apt. 415 21228 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after a and Mental Hygiene.
Is marked other than "natural", or Ital 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White þ 3 

Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Accountant Accounting 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic as George Mood Mary Freeland 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 144 Governors Way South, Queenstown, MD. James F. Mood, Jr. /son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Blair Memorial Park 03/30/05 Altoona, PA 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Sign ur Coster 1050 York Road, Towson, MD 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician disease or condition POZUMONIO resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (blooms or right) that initiated events Due to (or as a consequence of): Examine ysician and e burial-transit requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical ţ, yhd gulbr as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death esn 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy atter 10 Month Day Year in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) signed by the aid be detached f 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 Yes 2 No 3 Probably 4 Unknown Completed peeu 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 10 certificate has autopsy 2 10 1□ Yes or Attanding Physician: after death. Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 1 Yes 2 No Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) funeral 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27 Manner of Death Certification: 5 Pending Injury 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours af To the Funaral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier la rule D3098° March 26 2001 nd address of person who completed cause of death (Item 23a) (Type, Print)

State

MAR 2 8 2005 Registrar DHMH 17 Rev 1/2001

31. Dan filed (Month, Day, Year)

711 Maiden Choice La Cadonsville Mo

MD 2. Registrar's Signature

		-	= For Unpend	Item	Stat 23a&2	e of Ma <b>7 per</b>	ryland/l	Depar Certi	tment 4-05	of He tas	ealth a	and M	ental H	/giena	2005	)	104	23
	Physicia /Medic	an al	1. Decedent's Name (F Mark Antho 4a. Facility Name (If no	îrst, Middle, L ${f ny}  {f O}^{ f !}  {f C}$	<sub>ast)</sub> onner						Location o		2. Date of D Month MARCH	eath Da 20	y, 2005		3. Time of 7:41A	
	Examin uneral	G,	11 WARREN 5. Social Security Numb	ROAD	Sex 15 M 2	7. Age	(In yrs. last bi	rthday)	ESS:	EX	If Under:		8. Date of B	BA	ALTIMOI	RE	ace (State o	r Foreign
	rector	-	216-78-164 Usuel Residence of De 10a. State 10		10 <b>3</b> M 2C	4	2 10c. City, Tow	rn or Loca	tion	1			11-19	-1962		Mary	yland d. Inside Ci	ty Limits
ith the Man	or 28a-f sh se notified	Director	Md  10e. Street and Numbe	Baltim '	ore		Esse	ζ	10f. Zip (	Code				10g. Ci	tizen of What	Countr	1 ☐ Yes ry?	2 <b>(2</b> No
laryland 21215-0036 2 should be filed within 72 hours after death with the Maryland and Mental Hydlene.	of other than "natural", or items 23a or 28a-1 showevent, the Medical Examinar must be notified at	by Funeral	11 Warren  11. Marital Status  1 Never Married  3 Widowed 4	2 Married	Arm 1 🗀 If Ye	Decedent E ed Forces? Yes 2 Nes, Give r or Dates:			212 as Decede es, speci	ent of His fy Cubar	spanic Origin, Mexican	gin? (Spe , Puerto	ecify Yes or N Rican, etc.)	U.S.	14. Race - A Black, W	Vhite, et	tc.	
21215-0036 od within 72 hours aff	than "natura se Medical E	Completed	(Specify of Elementary/Secondary	. Decedent's only highest g ary (0-12)	rade compli	e <i>ted)</i> ege (1-4or 5-		life. DC	nd of worl NOT use	k done d e retired)	uring most	t of worki	ng		and of Busine		·	
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≥ ≥ €	tem 27 other tr		19a. Informant's Name Renee O CO  20a. Method of Disposi 1 □ Burial 2  C	nner			20b. Place of	78 B	York	way	Dune	dalk,	Mary 1. Date	and 2				
Baltimore, permit. Pages 1 a Department of Hea	Important: If i any injury or one		'4 Donation 5 E	Other (Spec	eify)	TOTA State	Green	22. 1	Name and	Addres	s of Facilit	yWise	-2005 e Fune ve Bai	ral S		es F	P.A.	
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after cleath.	After this funeral di	Certification: To Be	2 Accident	5 Pending investigat	be 200	Date of Injur (Month, Day		Time of Injury	М	3c. Injury Work 1 🗀 Y	r: 4 □ Nu	rsing Ho	n (Check only me 5 ☐ Re: 28d. Describe	sidence how inju	iry occurred			
Divi	0 0		4 Homicide  29a. Certifier 1		Physician:	building, etc	c. (Specify)  of my knowledg	ge, death o	occurred a	at the tim		d place,	City or To	e cause(s	e) s) and manne	r as sta	ated.	
To the Ho	To the Funaral Dir	Medical	(Check only one)  29b. Signature and title			the basis of d manner sta	examination atted.	nd/or inve	29c.		number	th occurr	ed at the time	29d. Da	d place, and ate signed (MCH 21,2)	lonth, D	Pay, Year)	
			30. Name and address	LE MI	o complete			(Type, Pr	r <sub>int)</sub> 1 Per	n S	treet	Ва	1timor				1	
演	Sta Registr		31. Date filed (Month,	_	2005		ar's Signature	Ap	ed)	•								

			For State Registrar	State of M	Maryland / Dep Ce	ertificate of			iene g. No.20 (	05 10424
	Physici	an	1. Decedent's Name (First, Middle	,				2. Date of Deat	h H <sup>Da</sup> Ž3, a	3. Time of Death
÷.	/Medic Examin		Ruth A. Peard  4a. Facility Name (If not institution Set 1 n t		Center	4b. City, Town, or	r Location of De			or Death Saltimore
	Funeral Director		5. Social Security Number 215–28–3187	6. Sex 7. A	nge (In yrs. last birthda) 74 Yrs.	If Under 1 Year Months Days	If Under 24 H	8. Date of Birth (Month, Day, 06/15/1	Year) 930	9. Birthplace (State or Foreign Country) Maryland
	sryland show	_	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or I	ocation				10d. Inside City Limits 1 ☐ Yes 2 X No
:	r 28a-f	Director	MD Balt  10e. Street and Number	imore	Glen Ar	10f. Zip Code		1	0g. Citizen of W	
ဖွ	int. Pages 1 and 2 should be lied within 72 hours after death with the Maryland artinent of Heatth and Mental Hygiene. Ordens: If lemm 27 is marked other than "natural", or items 23s or 28a-f show injury or other traumatic event, the Medical Eyamine must be notified at a.g	Funeral	12010 Somerse  11. Marital Status  1 Never Married 2 Marrie	12. Was Deceden Armed Forces	6?	21057  Was Decedent of H If Yes, specify Cuba	ispanic Origin? un, Mexican, Pu Specify:	(Specify Yes or No- erto Rican, etc.)		- American Indian, c, White, etc.
21215-0036	/2 nours 'natural', dical Exa	eted by	3 Widowed 4 Divorced  15. Decedent (Specify only highes	Year or Dates 's Education	16a. Dec (Giv	edent's Usual Occup	ation during most of a	vorking	16b. Kind of Bus	White
2121	e filed within al Hygiene. I other than " vent, the Wes	Completed	Elementary/Secondary (0-12)	College (1-4or	r 5+)	DO NOT use retired				g Retail Ind.
ug	uld be file fental Hy rked oth tic event	To Be (	17. Father's Name (First, Middle, Indiana)  Jennings Bryan					Name (First, Middle, M Ellen Bor		a)
Mary	id 2 should be Ith and Mental 27 is marked c 1raumatic eve		19a. Informant's Name/Relationsh	nip (Type, Print)		-511	and Number or	Rural Route Number,	City or Town, S	
	Pages 1 and 2 nent of Health int: If Item 27 i		Kathryn F. Be 20a. Method of Disposition 1 Burial 2 Cremation	3 □Removal from State	20b. Place of Disp cemetery, cri	osition (Name of ematory or other place	(8)	Date	20c. Location - (	Iaryland 21234 City or Town, State
	permit. Pages Department of Important: If I any injury or once.		4 □ Donation 5 □ Other (St. 21. Signature of Funeral Service I		1	22. Name and Addres	ss of Facility E	. F. Lassa	hn Fune	eral Home, P.A. eryland 21087
106	nysician		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition	only one cause on each	ed the death. Do not er	nter the mode of dyin	g, such as card			Approximate Interval Between Onset and Death
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Vital Record	has been the 2 shoul	Completed by		JAL SESTIMB	<u> </u>			24a. Was ar autopsy perform	pr led? de	ere autopsy findings available for to completion of cause of sath?  Yes 2 No
		o Be C	25. Was case referred to medical examiner?  1 \( \sum \text{Yes} \) 2 \( \sum \text{No} \)	Hospital: 1 kInpat	ient 2□ER/Outpatie	Othe	200	eath (Check only one Home 5 Reside	9)	
ion of	To the nospital or Auchining ringstrain, within 24 hours after death.  To the Eurharian Directors After this certific completely filled in by the funeral director.	-	27. Manner of Death  1 Natural 5 Pending 2 Accident investig	28a. Date of Inj (Month, D	ury 28b. Time	of 28c. Injury Work	at	28d. Describe hor		
Division	after death. I Director: After din by the funer	Certification:	3 Suicide 6 Could n 4 Homicide determi	ned 288. Place of in	njury - At home, farm, s atc. <i>(Specify)</i>	treet, factory, office		28f. Location (Str. City or Town,		r or Rural Route Number,
	o the hospital or Auditum Fri vithin 24 hours after death o the Euneral Directors After th ompletely filled in by the funeral	edical C	29a. Certifier (Check only one) Certifying	g Physician: To the best examiner: On the basis of and manner s	of examination and/or i	th occurred at the tim	ne, date and pla pinion, death oc	ice, and due to the ca curred at the time, da	use(s) and man te and place, ar	ner as stated. ad due to the cause(s)
F	within 2 To the	7	29b. Signature and title of certifier	elou, M.	<u>j</u> .	29c. License	number 7695			(Month, Day, Year) 23,2005
16	) (		30. Name and address of person v	ELOH M D	death (Item 23a) (Type		E TOWS	ON MARYL		
	Sta Registr	te ar	31. Date filed (Month, Day Year)	32. P	trar's Signature					

				1- For Amend Items	State of Ma 25,27,28a-	nylar	nd / Den	artmen	t of Hea	Ith and N		giene Reg. No.	201	75	1	
	т	Physici	an	Decedent's Name (First, Middle, La.							2. Date of Do Month	Day	Ye	ar	3. Time	of Death
	4	/Medio	cal	Edmund Charles F  4a. Facility Name (If not institution, giv.				4h Cin	Tour or Los	ation of Death	Feb	10	ZOO County of E	-	11	
		Examir	ier	3+ ARU-PS	Afeal A	. 0	0 0	10	1.1.	ation or beating		40.		n/a		
		Funeral Director		5. Social Security Number 6. S 213–18–7746	Gex 7. Age	o (In yrs.	last birthday) Yrs.	1000		Under 24 Hrs. ours Min.	8. Date of Bi (Month, Dec. 31	ey, Year)	9.	Birthpla Countr	ce (State y) land	or Foreign
		and w		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty. Town or Lo	ocation						100	d. Inside (	City Limits
		death with the Maryland ms 23a or 28a-f show Emusi Le notitied at	ō	Maryland Baltimo	re		Balti	imore							1 ☐ Ye	s ŽNO
		28a-	Director	10e. Street and Number	де		Dares	10f. Zip	Code			10g. Citiz	en of What	Countr	y?	-
		3a ol	D	4230 Hollins Fer	ry Road #1	15		2	1227			Uni	ted S	Stat	es	
		death	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		.S. 13.	Was Deced	lent of Hispan	ic Origin? (Sp	ecify Yes or No Rican, etc.)		4. Race - A Black, W	merica	n Indian,	
	036	ours after at', or Ita Examine	by	1 ☐ Never Married 25 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔯 N If Yes, Give Year or Dates:	lo		1 ☐ Yes 2		ecify:	, , , , , ,		Specify:		vhite	€
	215-0	within 72 hours after ene. then "natural", or Ita	Completed	15. Decedent's Ed (Specify only highest grades) Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5-	+)	16a. Dece (Give life.	dent's Usua kind of wor DO NOT us	l Occupation k done during e retired)	most of work	ing		d of Busine			
	7	filed wit Hygiene other the	Con	12			Wareh	nousem					ail S	Sale	s	
	Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturat", or Itams 23a or 28a-f show way injury or other traumatic event, the Medical Examinat must be notified at once.	To Be	17. Father's Name (First, Middle, Last) John Plantholt	)						e (First, Middle na Fred					
	an	2 sho and ie ma		19a. Informant's Name/Relationship (	-						al Route Numb					
	2	and lealth m 27		Stephen Plantholt	: / Son	205 (	113 Place of Dispo				timore,					
	0	Pages 1 nent of H int: If ite		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □			cemetery, crei	matory or of	ther place)	l			ation - City			
	ΕË	it. Partimer rtant: njury		*4 □ Donation 5 □ Other (Specification of Funeral Service Licer		Ba	yview		_		/2005		imore	•		and
	Ba	Depa Impo eny is		21. Signature 1 Furieral Service Licer	100	).					bbard F e, Balt					1220
_				23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lin	the deat				-	_		, mai	1	oproxima nterval Be Onset and	ate stween
		Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Str	188	wonen of							-	1	
1		Examiner	-	Sequentially list conditions,	b. Due to (or as a	va	tion	· p	neu	mos	wa				2	
+		and I-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Oue to (or as a	ral	- fi	brit	(ati	CLI		1/	)		4	
rol	8760,	cate be execu ohysicien and the burial-tra	cal		o. Left	/	hip	tr	autu	RTIFICATION	PROVED BY ME	DICAL EXAM	MINEF	•	7	
Planth	.O. Box 68	Attending Physiclen: The law requires that the death certificate be executed robath. of death. cortificate has been signed by the attending physicien and cotor: Atter this certificate has been signed by the attending physicien and by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at 1 9 Unknown	2 ☐ Feta	ildeath 3 ☐	⊒Ectopic pre ⊒ Other (spe	egnancy	RIPIDATIO		23	d. Date of Month	,		Year
-	<u>α</u>	uires that signed b id be deta	d by Pl	Part II. Other significant conditions of	contributing to death bu	t not res	ulting in the u	inderlying ca	use given in	Part I.	İ	obacco us Yes 2□	e contribute			death? Unknown
Z	00	w req	iete	hup-Ale	t-Core						24a. Was		24b. Were	autops	y findings	available
mund	l Re	The la ate has page 2	Somp	renal in	itulf? e	1-ev	VAA				auto perfo	psy rmed? 2. No	death	to comp ? 'es 2		cause of
7	/ita	clan: ertific ector.	Be	25. Was case referred to medical examiner?	Manadali				0.4		Check only		ere e e e			
Z	5	Physi this c	2	1X Yes 2 No			ER/Outpatier				me 5 Resi			pecify)		
TO D	uo	ding h. After funer	tion	1 € Natural 5 Pending	28a. Date of Injun (Month, Day		Injury	R.A	Bc. Injury at Work? 1 ☐ Yes		Subjec					
1	Division of Vital Records,	or Attendated after deatl	ertificat	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	04/07/40	ry - At h	4:p.m. ome, farm, str y)				28f. Location ( City or Tot 4230 Ho	Ctroat and	Alumbaras	Rural F	Route Nun	nber,
234	_	To the Hospital or Attending Physiclen: The law within 24 burns after death. within Funeral Director Attenthis certificate has completely filled in by the funeral director, page 2	Medical Certification:	29a. Certifier 1 Certifying Ph	ysician: To the best of niner: On the basis of and manner state	examina	wledge, death	h occurred a	at the time, da	te and place,	and due to the	cause(s) a	nd manner	as state	ed.	
3		To the within 7 To the comple	Me	29b. Signature and little of certifier	and maining stat			29c.	License num	ber		29d. Date	signed (Mo	onth, Da	y, Year)	
		- > <del>-</del> 0		30. Name and address of person who		11	10		D 58	-571		2	110		200	5
				LYNN T	Alo I	100	Cast		Byen	(int	Balt	Pino	ić.	MY	2 (	1221
		Sta Registr		31. Date filed (Month, Day, Year) MAR 2 2 200	5 Registra	r's Signa	ture doca	le								

DHMH 17 Rev 1/2001

				State of Maryland / Department of Health and	d Mental Hygie	2005 10426
				1 - Stete Registrar Certificate of Death  1. Decedent's Name (First, Middle, Last)	2. Date of Death	J. No. 3. Time of Death
		Physici	an	EDITH PAZ DERSKY	Month 03-	Day Year
	1	/Medio		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of De	100	4c. County of Death
		Exquiii	ięi	Franklin Square Hospital Center Rosedale		Baltimore
		Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 H	Irs. 8. Date of Birth in. (Month, Day, Y	
		Director		219-16-4852 10 M 20 F 80 Yrs. Months Days Hours M	MAY 6,1	924 MD
		pug ≱		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
		Aaryla f sho	ö	MS BALTIMORE White MARSH		1 ☐ Yes 2 ☐ No
		28a-	Director	10e. Street and Number 10f. Zip Code	100	g. Citizen of What Country?
		death with the Maryland ims 23a or 28a-f show I reast be notified at	D	4932 BUCKS School HOSERD. 21234		U.S.A.
		death	nera	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	(Specify Yes or No-	14. Race - American Indian, Black, White, etc.
~	9	or Its	/Fu	1 Never Married 2 Married 1 Yes 2 No	erto Micari, etc.,	Sansitu.
Ed. H	21215-0036	within 72 hours after ene. than "natural", or Ita ne Medical Exemina	Completed by Funeral	3d-Wildowed 4 □ Divorced Year or Dates:		While
2	7	n 72 nat	iete	15. Decedent's Education (Specify only highest grade completed)  (Give kind of work done during most of wife, DO NOT use retired)	vorking	6b. Kind of Business/Industry
W	212	with iene. r thar	шо	Elementary/Secondary (0-12) College (1-4or 5+)  Operator  Operator		Phone CORP.
(7)		e filad Il Hygie othar vant, Il	BeC		lame (First, Middle, Ma	iden Sumame)
36	12	2 should be filad within and Mental Hygiene. is markad othar than aumatic avant, I're Ma	To E	Steven Duhan My	ette Wi	115
Pazoersky	Maryland	s 1 and 2 should be filad within 72 hours after death with the Marylan I Health and Mental Hygiene. item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or	Rural Route Number, C	City or Town, State, Zip Code)
12		1 and 2 Health em 27		JOAN PAZDERSKY Drug/ITW 4932 Pucks >		LSR RO
2	Ö	Pages 1 nent of h int: If ite iry or of		1 ☐ Burial 2☐Cremation 3 ☐Removal from State   cemetery, crematory or other place) 3	25/45	
	Saltimore,			*4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee  22. Name and Address of Facility	5705	Balto. W.
	Ba	permit. Departr Imports any inji		Verland Stella 7527 has FORD A	D. BAIts	mern I Home CHTD. Ms 21734
	П			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card shock, or heart failure. List only one cause on each line.	iac or respiratory arrest	Interval Between
	Ų	Pnysician		Immediate Cause (Final disease or condition	chon	Onset and Death
		/Medical Examiner		resulting in death)  Due to (or as a consequence of):	1	1 1 10 10
			70	Sequentially list conditions, if any, leading to immediate Due to (or as a con equence of):	mealur	ms. years
	1	ecuted and -transit	Examiner	cause. Enter Underlying		
	ó	Ø ⊂ Ø		that initiated events c.  resulting in death) Last  Due to (or as a consequence of):		
	8760,	cate be ex physician the burial	dicai	d,		
	9	ntifica ng ph s as th	Med	IF FEMALE:		
	300	eath certifi attending p	lan/	23b. Was decedent pregnant in the east 12 months?  23c. If yes, outcome of pregnancy  1		23d. Date of delivery  Month Day Year
	Division of Vital Records, P.O. Box	tha thechec	Completed by Physician/Me	1   Yes 2   No 9   Unknown   4   Pregnant at time of death 5   Other (specify)		
	٥.	that the od by detac	/ Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death?
	sp.	v requires tha been signed should be del	d b	COPD	1) Yes	2 No 3 Probably 4 Unknown
	00	aw requas been 2 should	ojete	Htopula nidologia	24a. Was an	24b. Were autopsy findings available
	Re	The lay	шо	12 well of blooding	autopsy performed	prior to completion of cause of death?  No 1 Yes 2 No
	ital	ysician: The	BeC	25. Was case referred to medical examiner?	eath (Check only one)	
	f V	Physic this ce al dire	To	1 ☐ Yes 2.2 No Hospital: 1 ☐ Inpatient 2 DER/Outpatient 2 DOA Other: 4 ☐ Nursing		e 6 Other (Specily)
	n c	ding P. After t funera	ion:	27. Manner of Death  1 Natural 5 Pending (Month, Day Year)  28a. Date of Injury 28b. Time of Injury Work?  1 Natural 5 Pending (Month, Day Year)  M M 1 Yes 2 No	28d. Describe how	injury occurred
	isio	ottandi death. ctor: A y the fu	icat	3 Suicide 6 Could not be an allow of lawy 4t home farm street feature office	28f. Location (Stree	et and Number or Rural Route Number,
	Div	after Dirac	Certification:	4 Homicide determined determined building, etc. (Specify)	City or Town, S	State)
	_	To the Hospital or Atlanding Ph within 24 hours after death. To the Funeral Diractor: After th completely filled in by the funeral		29a. Certifier 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and pla		
		he Hc in 24   ha Fu pletely	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death ocone)  and manner stated.		
		To the To the Comp	Σ	29b. Signature and title of certified 29c. License number		Date signed (Month, Day, Year)
	•	4		Magle 5 / M. 11958	9	3-23-05
		10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	( 4 10 D -	Touknal sin 71700
		Sta	to	EVAN GELOS LIGNOS 7801 XORK RIOL  31. Date filed (Month, Day, Year)  32. Paistrar's Signature	12100	lonson Will and
		Registi		MAR 2 8 2005 Seem & Sparke		1

Patient Known as Powell, Gerald Baltimore. Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure Al	I Copies Are Legible.
State of Maryland / Department of Health and M	lental Hygiene

			- Troubb 1	State of Maryland	/ Departme	nt of Health and N	lental Hygi	ene	
			For State Registrar		Certifica	ite of Death		g. No. 2 1 1 E	101.27
	Physicia	an	1. Decedent's Name (First, Middle, Last)	- D	1.7		2. Date of Death Month	Day Year	3. Time of Peatin /
	/Medic	al	berald	La POL	uell	y, Town, or Location of Death	March	23 2005 4c. County of Deat	
	Examin	er.	4a. Facility Name (If not institution, give st. 5 indi HOSP: ta			11.	4	1/10	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la		ler 1 Year   If Under 24 Hrs.	8. Date of Birth (Month, Day,	Year) 9. Birt	hplace (State or Foreign
	Director		213-54-2184	M 20 F 54	Yrs.	Says House	July 9	, 1951 M	any land
	and ow it	-	Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Location				10d. Inside City Limits
	Mary I-f sho	tor	MD NIC	2	Balti	more	_		1 Pres 2 □ No
	death with the Maryland ms 23a or 28a-f show r must be rediffed at	Director	10e. Street and Number		10f. 2	Zip Code	10	og. Citizen of What Co	ountry?
	ath wi	rai	1437 Limit	- the Apt.	A	21239	positu Vas ar No	14. Haçe - Ame	/
	ter de Itams	Funeral	11. Marital Status  1 Never Married 2 Married	<ol> <li>Was Decedent Ever in U.S Armed Forces?</li> <li>1 ☐ Yes 2 ☐ No</li> </ol>	If Yes, s	pedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto	Rican, etc.)	Black, Whit	
5-0036	hours after tural; or Ita	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 🗆 Yes	2 No Specify:		Specify: B	Jack
2 2	72 ho	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Decedent's U (Give kind of life. DO NO	work done during most of worl	king	16b. Kind of Business	/Industry
121	within 72 ene. than "nai	ıdmo	Elementary/Secondary (0-12)	College (1-4or 5+)	Housi		tac	City of	Baltimore
0 7	filed with Hygiene other tha	BeCc	17. Father's Name (First, Middle, Last)		11000		e (First, Middle, M	Maiden Sumame)	Doct to tripe to
<u>lan</u>	2 should be filed within 72 hours after death with the Marylan and Menhal hygiene is marked other than "natural; or hams 23a or 28a-f show aumatic evant, the Wedical Evairs are must be notified as	To B	William	owell		Mil	dred		v n
Maryland			19a. Informant's Name/Relationship (Typ	De, Print) 3 ster	19b. Mailing Addre	ess (Street and Number or Ru	4	1 9470 000	1
	s 1 and if Health itam 27 othar ti		20a. Method of Disposition	POWELL 20b. Pk	1431 L ace of Disposition (f	vame of	Date Date	20c. Location - City or	21239 Town, State
nor	90 = 5		1 Burial 2 □ Cremation 3 □ Re '4 □ Donation 5 □ Other (Specify)	emoval from State	metery, crematory o	4	ch 30,2005 l	anedo	MA. MA
altimore,	artn orts inju		21. Signature of Funeral Service License	0	22. Name	and Address of a cill	1.	al Home	0.4
ä —	Depa Impo any i		Totelle J.	Thomas X:	M. 22	ala W. Nort	h Ave	Bell To. M	0 21216
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	ations that caused the death. a cause on each line.	. Do not enter the n	node of dying, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Sepsis	0				2 weeks
	Examiner			Auto Re	ence or):	: luve			1 month
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequent	ence of):	110016			
	acuted and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	anno of):				
760,	te be executed sysician and ne burial-transit	cai E	rossing in south, and	Due to (or as a consequ	ance on.				
687	a X a		d						
Вох	eath certific attending pl	M/UE	23b. Was decedent pregnant	3c. If yes, outcome of pregnar		c pregnancy		23d. Date of de Month	livery Day Year
O. B	es that the death cert igned by the attendin be detached for use	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of de 9 Unknown				Wicklin	Day (Sai
<u>α</u>	that the		Part II. Other significant conditions con	tributing to death but not resu	Iting in the underlying	g cause given in Part I.	23e. Did tol	pacco use contribute to	o the cause of death?
rds,	The law requires that the death certifica ate has been signed by the attending ph bage 2 should be detached for use as it	d by	Congestive h	reart fail	lure		1 □ Ye	es 2□No 3□P	robably 4 Unknown
00	aw requir s been si 2 should 1	piete		dent diabe		11:445	24a. Was a	v prior to	utopsy findings available completion of cause of
Vital Records,		Completed by		ve, - v, - j.		,,,,,,,	perform		
/ita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	lospital:		Other	th (Check only on		
of	S S	-: To	1 Yes 2 No	28a. Date of Injury	28b. Time of	DOA 4 Nursing H 28c. Injury at Work?		ance 6 □Other (Spe ow injury occurred	ecity)
ion	Attending F r death: ector: After by the funer	atior	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury M	Work? 1 ☐ Yes 2 ☐ No			
Division	ter destination	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury · At hor building, etc. (Specify,	me, farm, street, fac	ctory, office	28f. Location (Si City or Town	reet and Number or R n, State)	lural Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		CO- Co-stiller & Constitution Phys	sician: To the best of my know	wlodgo, doeth coorr	red at the time, date and place	and due to the c	ause(s) and manner a	s stated
	24 hos 24 hos e Fun etely (	edical	29a. Certifier Certifying Phys (Check only 2 Medical Examir one)	ner: On the basis of examinati and manner stated.	ion and/or investiga	tion, in my opinion, death occu	rred at the time, d	ate and place, and du	e to the cause(s)
	To the To the To the Comple	Me	29b. Signature and title of certifier			29c. License number	2	9d. Date signed (Mon	th, Day, Year)
	/		HBasha	~ MD		KE 5-000	A	Narch, 23,	, 6005
	1		30. Name and address of person who co	1	23a) (Type, Print)	Hospital	of Bu	Himore	2
	St.	ate	31. Date filed (Month, Day, Year)	32. Registar's Signat	)	A A	00		
	Regist		MAR 2.8	2005 Blown	15 A				

		I.	For 1 - State Registrer	State of M		Depa	artment of tificate of	Health a	and Ment	-	ne 2 0 1	05 10428	
	Physici /Medio Examir	cal	1. Decedent's Name (First, Middle, L  MARY 4a. Facility Name (If not institution, g	ive street and number			4b. City, Town	, or Location	MA	Pate of Death Month	Day 25 2 4c. County of	3. Time of Death Year OOS 2:25 AM I Death	
	Funeral Director			RITAN Sex 10 M 200 F 7. A	HOSPi- age (In yrs. last 91		If Under 1 Yes Months Day	r If Under	24 Hrs. 8. D Min. (A	RE Pate of Birth Month, Day, Yel  Tember 6	n/a ar) 1913	9. Birthplace (State or Foreign Country) MaryLand	
	he Maryland 18a-f show officed at	Director	10a. State 10b. County  MD Balt	imore	10c. City, To	erry	Hall			100	Citizen of Wh	10d. Inside City Limits 1 ☐ Yes 2 ☒ No	
<sub>Q</sub>	be filed within 72 hours atter death with the Maryland that Hygiene.  id other than "natural", or items 23a or 28a-f show event, the Medical Examinational the Inditing at	Funerai	10e. Street and Number  9603 Brookbend  11. Marital Status  1 Never Married 2 Married	12. Was Deceder Armed Forces	?		Vas Decedent of Yes, specify Co	236 f Hispanic Or uban, Mexica			14. Race Black,	J.S.A.  - American Indian, White, etc.	
Maryland 21215-0036	ithin 72 hours a ne"naturel", o ne"naturel", o	Completed by	3 Widowed 4 Divorced  15. Decedent's (Specify only highest g Elementary/Secondary (0·12)	College (1-40	10	6a. Deced (Give life. L	lent's Usual Occ kind of work dor OO NOT use reti	upation ne during mos red)		16b		White iness/Industry	
yland 21	be d la la la la la la la la la la la la la	To Be Cor	12 17. Father's Name (First, Middle, La: Robert F.	n/a st) Long		5	elf-emp	18. Moth	er's Name (Firs becca	st, Middle, Maid	len Sumame,	/Retail      lliams	
	rt 2 mg		19a. Informant's Name/Relationship Ruth Mierzwicki- 20a. Method of Disposition	daughter	20b. Place	+720 of Dispos	g Address (Stre T Water  sition (Name of natory or other p	Park		elcamp,	MD 2	tate, Zip Code) 1017 iity or Town, State	
Baltimore,	permil. Pages 1 ar Department of Hea Important: if Item any injury or othe once.		1 ☐ Burial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Special Service Lice)  21. Signature of Funeral Service Lice	city)	° Qulaney	/ Valle	ey Mem'l I	Gard Iress of Facili		1			
	Physician /Medical Examiner	her	23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, lary, leading to immediate cause. Enter Underlying Cause (Disease or injury)	a. Due to (or a	ed the death. Colline.  VEV/ is a consequence.  SEP	MOr ce of): Sis	or the mode of d					Approximate Interval Between Onset and Death	
68760,	titicate be executed ng physician and as the burial-transit	Medical Examiner	that initiated events resulting in death) Last										
P.O. Box	that the death certiticat ed by the attending phy detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Vas decedent pregnant I the past 12 months?  Yes 2 No Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown								h Day Year	
	aw requires is been signi	Completed by	Part II. Other significant conditions	contributing to death	but not resulting	g in the ur	nderlying cause	given in Part I	]	1 ☐ Yes	cco use contribute to the cause of death?  2 No 3 Probably 4 Unknown  24b. Were autopsy findings available prior to completion of cause of		
of Vital Records,	Physician: The L this certificate ha al director, page	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:		performed? death?  1 Yes 2 No 1 Yes 2 No  26. Place of Death (Check only one)							
Division o	or Attanding I tter death. Director: Atter in by the funer	Certification;	27. Manner of Death    Salaria   5   Pending	be 28e. Place of I	njury - At home, etc. (Specify)	b. Time of Injury		☐Yes 2☐	No 28f. L	Describe how in ocation (Street City or Town, St	and Number	or Rural Route Number,	
	To the Hospitel or Attan within 24 hours after deat To the Funeral Director: completely tilled in by the	Medical Ce	29a. Certifier (Check only one) 1 Certifying I Medical Ex	Physician: To the bes aminer: On the basis and manner	of examination	dge, death and/or inv	estigation, in m	y opinion, dea	nd place, and d ath occurred at	the time, date a	and place, an	d due to the cause(s)	
)	Tot	Σ	29b. Signature and title of certifier  30. Name and address of person wh	Ban o completed cause of		a) (Type,	DO	nse number 0 0 S	8913 mari	MA	ARCH	(Month, Day, Year) $25  2005$ $Pi  TAI$	
5	Sta Registi		30. Name and address of person who MANISHA BAN 31. Date filed (Month, Day, Year)		Strar's Signature	601	LOCH	RAVE	N BO	VLEVA	RD, ARYL	BALTIMORE AND 21239	
DH	MH 17 Rev 1/2	2001		1000		RIGIN	AL						

		= 1	For State Registrar	State of	Marylan	-	artmen rtificate				ental Hy	giene Reg. No.	2005	10429
	Dharaini		1. Decedent's Name (First, Middle, Last	)							2. Date of De	aath Day	Year	3. Time of Death
	Physicia /Medic		William C.	Poe							March		2005	6:00 P M
	Examin	er	4a. Facility Name (If not institution, give				4b. City,		Location of	of Death		4c.		
			Greater Baltimore  5. Social Security Number 6. Se		I Cente 7. Age (In yrs. I		If Under	Tows	SON If Under	24 Hrs.	9 Date of Bir	th		
	Funeral Director			M 2□F	90	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da March	Year)	15 Mary	untry) Vland
			Usual Residence of Decedent	·						1		.,		
	nylan show		10a. State 10b. County		10c. City	r, Town or Lo	ocation							
	Ba-f s	Director	Maryland Baltimor	е	To	owson								
	vith th	Dire	10e. Street and Number				10f. Zip	204				USA		untry?
	s 23s	Funeral	615 Chestnut Ave.	12 Was Doce	dent Ever in U.	e 13 1			ispanic Ori	gin? (Spe	offy Ves or No			rican Indian
	ter de Item	-un	11. Marital Status  1 Never Married 2 Married	Armed For	rces? 2 □ No				n, Mexicar	n, Puerto	city Yes or No Rican, etc.)	,		
990	urs af	by	3X Widowed 4 □ Divorced	If Yes, Giv Year or Da	9 Irllil 9	I	1 🗆 Yes	2 <b>X</b> □ No	Specify:				Specify: Wh	nite
20-0	72 ho	Completed	15. Decedent's Edu (Specify only highest grad	cation		16a. Dece	kind of wo	rk doné d	during mos.	t of workii	na	16b. Kir	nd of Business/	Industry
2 2	ithin he.	nple	Elementary/Secondary (0-12)	College (1	-4or 5+)	life.	DO NOT us	se retired	)			Balt	timore (	Gas &Electri
2 2	fled w tygier her th		17. Father's Name (First, Middle, Last)			ıran	sport	atio		ar's Name	(First, Middle	Maiden	Sumama)	Year  2005 6:00 P  Sounty of Death  Baltimore  9. Birthplace (State or Foreign County)  Maryland  10d. Inside City Limits 1 Yes 2 No  In of What Country?  Race - American Indian, Black, White, etc.  Pecify: White Inf Business/Industry  imore Gas & Electric  Soundard  Town, State, Zip Code)  Md. 21131  Ittion - City or Town, State  Inium, Maryland  1050 York Road  Towson, Md. 21204  Approximate Interval Between Onset and Death  Year  Interval Between Onset and Death  Year  Contribute to the cause of death?  No 3 Probably 4 Unknown  24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
anc	t be find he of	Be	Andrew Po						Eth			gers	ourramo)	
. WiWIGNW Maryland 21215-0036	should nd Me mark matic	7	19a. Informant's Name/Relationship (T)			19b. Mailir	ng Address	(Street a					r Town, State, Z	lip Code)
	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, Ite Modical Exertiner must be notified at once.		Nancy Eitel / Daug	hter										
Je,	s 1 a of Hea Item		20a. Method of Disposition		20b. P	lace of Dispo	osition (Nan	ne of ther plac	e)	C	ate	20c. Lo	cation - City or	Town, State
E E	Page nent c int: If		1 X Burial 2 ☐ Cremation 3 ☐ F  1 4 ☐ Donation 5 ☐ Other (Specify)			ys Cha				3/26/	05	Timo	onium,Ma	aryland
Recognition (1906)	permit. Departn Imports any Inju		21. Signature of Funeral Service Licens	9///			2. Name an			•				
	89 = 29		Shipla do	se									Towson	
_			23a. Part. Enter the disease, or comp shock, or heart failure. List only of	lications that ca ne cause on ea	aused the death ach line.	n. Do not ent	ter the mod	e of dyin	g, such as	cardiac o	r respiratory a	rrest,		Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)				ctive	Pul	mona	ry	Disca.	se		
	/Medical Examiner		resulting in death)	Due to (	or as a consequ	uence of):				•				
		6	Sequentially list conditions,	b	or as a consequ	uence of):								
	nted Inslt	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury											
Ć,	execting and training	Exa	that initiated events resulting in death) Last	Due to (	or as a consequ	uence of):								
760,	te be ysicia ne bur	cal		d										ork Road , Md. 21204  Approximate Interval Between Onset and Death Years
89	ng ph	Med	IF FEMALE:											
Š	ath ce tendi	an/l	23b. Was decedent pregnant in the past 12 months?	1 Live bi	come of pregna irth 2 🗌 Fetal	death 3	⊒Ectopic pr					2		,
P.O. Box 68	the enthed for	Physician/Med	1 Yes 2 No	4∏Pregna 9∏Unkno	ant at time of de wn	eath 5	Other (sp	ecify)				,		
9.	that the	Ph	Part II. Other significant conditions co	ntributing to de	ath but not resu	ulting in the u	nderlying c	ause give	en in Part I.		23e. Did 1	obacco us	se contribute to	the cause of death?
ds,	uires sign	d by	Clostridiu	n diff	icile C	olitis					128	Yes 2	□No 3□Pro	obably 4 Unknown
cor	w req beer shou	lete									24a. Was	an	24b. Were au	topsy findings available
Re	he la e has age 2	Completed									auto perfo	ormed?	death?	
ta	an: T	a	25. Was case referred to medical						26. Place	of Death	(Check only		1 103	212110
<u> </u>	ysici is cer direc	To B	examiner? 1 ☐ Yes 2 🕱 No	Hospital:	npatient 2	ER/Outpatier	nt 3 DC	Othe	эг: 4 <b>≥</b> Nu	rsing Hor	ne 5 Resi	dence 6	Other (Spec	city)
0 U	ng Pt fter th neral		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date o (Mont)	of Injury h, Day Year)	28b. Time of Injury	f 2	8c. Injury Work			28d. Describe	how injury	occurred	
Sio	tendii eath. or; A the fu	catle	2 Accident investigation 3 Suicide 6 Could not be				М		Yes 2			2:		
Division of Vital Records,	or At offer d Direct in by	Certification:	4 Homicide determined	28e. Place buildir	of Injury - At ho ng, etc. (Specify	me, farm, str ')	reet, factory	/, office		4	City or To			rai Houte Number,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit	ledical Ce			asis of examinat									
	othe ithin i	Mec	29b. Signature and hale of certifier	7	stated.		290	. License	number			29d. Date	e signed (Month	i, Day, Year)
	⊢s⊢ŏ		I for Slo	es in	no			000	6119	9		May	rch 24	1 2005
	111/		30. Name and address of person who c	ompleted caus	e of death (Item	23a) (Type,	Print)	^	9 11 6	-	>		-1 0:	2 0
1	1.01		Jason Black 31. Date filed (Month, Day, Year)	656	5 NOV P	char h	es 2,1	- S	rite)	03	lowson	a n	11) 21	204
	Sta Registr	· * · #	MAR 2 8 200	5	Tess B	Gos	ules							

					aryland / De			•	•	
			State Registrer			ertificate of			No.2005	10430
	Physici	an	Decedent's Name (First, Middle, Last		-			2. Date of Death Month	Day Year	3. Time of Death
50	/Medio	cal	FRANCES MARY  4a. Facility Name (If not institution, give			4b. City, Town,	or Location of Death	March 1	4c. County of Deatl	
3/6	EXAMI	iei	STELLA MARIS @ MEI		ΓΑL	BALTIM			N/A	
1/2	Funeral		5. Social Security Number 6. Se	x 7. Ag	e (In yrs. last birthda 98 Yrs.	Months   Davs		8. Date of Birth (Month, Day, Y JUNE 7,	(ear) 9. Birth	nplace (State or Foreign untry)  MD.
	Director		219-30-1935 Usual Residence of Decedent	Λ	90			JUNE 7,	1900	
٧ د	lanylan show	'n	10a. State 10b. County		10c. City, Town or					10d. Inside City Limits 1 ✓ Yes 2 □ No
3700	with the Maryland is or 28a-1 show	Funeral Director	MD . N/A		BALT	10f. Zip Code		10g	. Citizen of What Co	71
103	23£ or	ai Di	603 S. ANN STREET	, APT. 613	3	2	21231	U	INITED STA	TES
<i>d</i> ,	er death Items 23	uner	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Decedent Armed Forces?	Ever in U.S.	<ol> <li>Was Decedent of lif Yes, specify Cub</li> </ol>	Hispanic Origin? (Sp pan, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
1	72 hours after natural', or Ite	þ	3 ▼Widowed 4 □Divorced	1 □Yes 2 ☑1 If Yes, Give X Year or Dates:		1 ☐ Yes 2 No	Specify:		Specify: W	HITE
C. thoush	72 ho	Completed	15. Decedent's Edu (Specify only highest grad	ication le completed)	(Gi	cedent's Usual Occu ve kind of work done b. DO NOT use retire	during most of work	ring 16	b. Kind of Business/l	ndustry
7, 5	I within liene.	ошо	Elementary/Secondary (0-12) 6TH	College (1-4or 5	5+)	HOMEMAKER	, a		OWN HOME	
63	e filectal Hyg	BeC	17. Father's Name (First, Middle, Last)					e (First, Middle, Ma		
R. + Kowski	Laf y fall of L L L L L L L L L L L L L L L L L L	70	ANTHONY KLUCZYNSK		19h Ma	iling Address (Stree	<u> </u>	TTE PIECH	IUUK L City or Town, State, Z	in Code)
	C 2 4 5		JOSEPH RUTKOWSKI/			•			N, MARYLA	
	of Health of Health If item 27 I		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ I	Removal from State	cemetery, c	sposition (Name of rematory or other pla	ice)		c. Location - City or	
	Definition Pages 1 Department of Filmportant: If ite any injury or ot one.		*4 ☐ Donation 5 ☐ Other (Specify, 21. Signer re of Funeral Service Licens	1	HOLY RO		3/18		LTIMORE, ZEILER & S	
G	Dermi Depa Impo any ir		Madeth	Evan	w)				RE, MARYLA	•
	*		23a. Part1. Enter the disease, or comp shock, of heart failure. List only of	lications that caused ne cause on each li	the death. Do not a	enter the mode of dy	ing, such as cardiac	or respiratory arrest	,	Approximate Interval Between Onset and Death
•	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a		ever	devention			Onset and Death
	Examiner			Due to (or as	a consequence of):					
	P #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Observed in the year that initiated events	Due to (or as	a consequence of):					
V	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):					
76.0	0 0	cai		d						
Ö	entifica ling ph e as th	Physician/Medi	IF FEMALE:	20. 16						
2	eath c attend	cian/	in the past 12 months?	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at	2 Fetal death	3 □Ectopic pregnand 5 □ Other (specify) _	:у		23d. Date of deli Month	very Day Year
0	by the	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknoyn	9□ Unknown						
		by	Part II. Other significant conditions co	ntributing to death b	ut not resulting in the	e underlying cause gr	ven in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
	v requ	Completed						24a. Was an		topsy findings available
ć	The la	фшо						autopsy performe 1 ☐ Yes 2 ☐	d? prior to death?	ompletion of cause of 2 No
3	cian:	Bec	25. Was case referred to medical examiner?	Hamital		0:		h (Check only one)		
-	Physi Physi r this o	To To	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1 🗍 Inpatie 28a. Date of Inju	ry 28b. Time	of 28c. Inju	iry at	ome 5 Residence 28d. Describe how	e 6 dother (Specinjury occurred	hospice
1	ath. or: Afte	atior	1 Natural 5 Pending 2 Accident investigation	(Month, Da	y Year) Injur		ork? ]Yes 2∐No			
	or Atte	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj building, et	ury - At home, farm, c. (Specify)	street, factory, office		28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
	spital hours a meral i								se(s) and manner as	
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medicai	(Check only one)  2 Medical Exem	and manner sta	ated.		opinion, death occur se number		and place, and due	
	To To		Signature and title of certifier	,		ZSC. LICOTI	DXSLI	230	3/14/201	**
	7		30 Name and address of person who co	ompleted cause of d	leath (Item 23a) (Typ	pe, Print)				
	1		31. Date filed (Month, Day, Year)	berg 32. Registr	ar's Signature	Paul Pi	Balt	more m	rd. 21	705
	Sta Regist			005	ice B. 1	Constant of				

			T - For State Registrar	State	of Marylai		artment of h		d Mei	_	giene Reg. No.	005	10431
		v	Decedent's Name (First, Michael Control of the	idle, Last)					2.	Date of De	ath		3. Time of Death
	Physici /Medio		Brian Thomas	Russo						Month MARC	Н 25,	E ZiZi	5 2:48 PM
}	Examir		4a. Facility Name (If not institution Saint Jose	ion, give street and reph Medic		nter	4b. City, Town, o	17548	Death W S O T		4c. Coi	unty of Death Balt	cimore
	Funeral Director		5. Social Security Number 214-94-4587	6. Sex 1 X M 2 ☐ F	7. Age (In yrs. 40	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours		Date of Birt (Month, Da	, Year) , 196	9. Birth	pplace (State or Foreign intry) 'y land
	pug *		Usual Residence of Decedent 10a. State 10b. Cour	htv.	10c C	ity, Town or Lo	ocation						104 1-14- 67-11-7-
	Maryla f sho	20		imore		hervil							10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	the l	Director	10e. Street and Number	Tillot C	Luc	TICI VIII	10f. Zip Code				10g. Citizen	of What Cou	
	th with	al D	8330 Tally Ho	Road			21093				USA		
36	be filed within 72 hours after death with the Maryland ital Hyglene. dother than "natural", or Items 23a or 28a-f show event. The Medical Ever it as missible redifficial.	by Funeral	11. Marital Status  1 □ Never Married 2 ☑ M  3 □ Widowed 4 □ Divorce	Armed I arried 1 ☐ Yes	s 2 [ <b>7</b> No Give		Was Decedent of Hif Yes, specify Cuba 1 Yes 2 No	lispanic Origin an, Mexican, P Specify:	? (Specify uerto Ric	Yes or No- an, etc.)		Race - Amer Black, White ecity:	, etc.
9	2 hou atura		15. Deced	ent's Education		16a. Dece	dent's Usual Occup	ation			16b, Kind o	w of Business/Ir	hite
215	withIn 7; ene. than "n	Completed	(Specify only high Elementary/Secondary (0-12	nest grade completed  College		(Give	kind of work done DO NOT use retired	during most of d)	working				·
7	filed with Hyglene. Ither than	Соп	12		(1-4or 5+)	Financ	cial Anal						on Energy
Maryland 21215-0036		To Be	17. Father's Name (First, Middle Frank Anthony	·				18. Mother's Claire			Maiden Sun I <b>illi</b> an		
Jan	" = m =		19a. Informant's Name/Relatio				ng Address (Street						
	1 and Health em 27 ther t	- 1	Cynthia Ebert 20a. Method of Disposition	Russo /	wife		Tally Ho	Road;	Luth				
Baltimore,	permit. Pages 1 and 2 Dep rtment of Health a Important: If item 27 ts any injury or other tra once.		1  Burial 2  Crematio 1  Donation 5  Other	(Specify)	m State	cemetery, crer	ley Mem Gar			1	Timoni	on - City or T	
Bai	Dep r Dep r Impor any in		21. Signature > Fure all Sen	Chy		Ru	P. Name and Addre	n Funer	ral F	lome	Tows	York	Road D 21204
i,			23a. Part1. Enter the disease, shock, or heart failure. L	or complications that st only one dause on	t caused the dea each line.	th. Do not ent	er the mode of dyin	g, such as car	diac or re	spiratory ar	rest,		Approximate Interval Between
	Priysician		Immediate Cause (Final disease or condition resulting in death)	ANC	XIC EN	ICEPHA	LOPATHY						Onset and Death 5 DAYS
	/Medical Examiner		rosaning in asani)		o (or as a consec		ARCTION						5 DAYS
	3 00	er	Sequentially list conditions,	b	u (ur as a curised		7111072014					-	U Drift
	cuted nd ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	6									
Ö,	icate be executed physician and s the burial-transii	I Ex	resulting in death) Last	Due to	o (or as a consec	quence of):							
68760,	cate b	edical		d.				_	_		_	-	
_	= 0 4	/Me	IF FEMALE:	23c. If yes, o	utcome of pregna	ancv							
Box	0 0	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live 4□Pre	birth 2 Feta gnant at time of c	al death 3	Ectopic pregnancy Other (specify)					Date of deliv Month	ery Day Year
P.O.	law requires that the as been signed by th 2 should be detache	hys	9 🗆 Unknown	9□ Unk					-				
	res the	by	Part II. Other significant condi	tions contributing to	death but not res	sulting in the ur	nderlying cause give	en in Part I.					he cause of death?
Orc	w require been si should b	eted							_			3 ∐ Prot	pably 4 Munknown
Vital Records,	The ate h page	Completed					<u> </u>		_	24a. Was a autop: perfor 1 Yes	sy	<ul> <li>b. Were auto prior to co death?</li> <li>1 \(\sumeq\) Yes</li> </ul>	opsy findings available impletion of cause of
/ita	Phyaician: The this certificate haral director, page	Be (	25. Was case referred to medic examiner?	the same of the				26. Place of	Death (C	heck only or	ne)		
o	Phya this c	- To	1 ☐ Yes 2X No 27. Manner of Death		-	ER/Outpatien		4 🗀 1401\$111			ence 6 🗆 (		ý)
	ding h. After fune	tlon	1 XNatural 5 ☐ Pend	ding 28a. Date (Mo	nth, Day Year)	28b. Time of Injury	28c. Injun Worl	rat <br Yes 2 □ No	280.	Describe n	ow injury occ	curred	
Division	Attending or death. octor: After by the fune	ifica	3 ☐ Suicide 6 ☐ Coul	d not be 28e. Plac	e of Injury - At h	ome, farm, stre	eet, factory, office		28f.	Location (S	treet and Nu	mber or Rura	al Route Number,
-	tal or s afte al Dire	Certification:	4 Homicide dete	buil	ding, etc. ( <i>Specii</i>	(y)				City or Tow	n, State)		
	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	edical (	29a. Certifier 1 Certify (Check only one) 2 Medical	ring Physician: To the al Examiner: On the and ma	ne best of my kno basis of examina nner stated.	owledge, death ation and/or inv	occurred at the time time estigation, in my of	ne, date and pl	ace, and	due to the c t the time, c	ause(s) and late and plac	manner as s e, and due to	tated. o the cause(s)
	To ti To ti comp	M	29b. Signature and title of certif				29c. License	number		2	29d. Date sig	ned (Month,	Day, Year)
	4		trust (	allics. L	M.O.		D 36	5663			Mari	N 26,	5002
1	0		30. Name and address of perso	n who completed cau	use of death (Iter	п 23а) (Туре, 1	Print)						
			STUART R. W 31. Date filed (Month, Day, Yea	ILLES, M	Begistrar's Signa	6/21 OS	SLER DR	IVE, T	OWS	DN, M	ARYL	S QNE	1204
	Sta Registr	4.67			Payer .		artis.						

Physici /Media		1. Decedent's Name (First, Middle, Last)  Nama S	tokes				2. Date of D	aath 23 <sup>Day</sup>	7.005	3. Time of Death	
Examir		4a. Facility Name (If not institution, give stre	net and number)	id Hosi	pital	or Location of Death	1	<del>-</del>	County of Death	1,71	
Funeral Director		5 Social Security Number 212 48 1247  Usual Residence of Decedent	2□F	s. last birthday 57 Yrs.	If Under 1 Year Months Days		8. Date of Bi (Month, D		9. Birthp Coun Mary	•	
within 72 hours after death with the Maryland ene. Than "ratural", or liems 28a or 28e-f show tra Madical Examinar must be notified at	ector	10a. State 10b. County 10c. City, Town or Location  Baltimore  10e. Street and Number 10f. Zip Code 10g. Citizen of Wh.									
23a or 3		2601 Orleans Street			10f. Zip Code	21224		U.S.	en of What Coun	try?	
ral', or Items Examinar m	by Funeral	11. Marital Status 12.  1 Never Married 2 Married 3 Widowed 4 Divorced	Was Decedent Ever in Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cui 1 ☐ Yes 2 ☐ No	Hispanic Origin? (Spoan, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	D- 14	4. Race - Americ Black, White,		
ntal Hygiene. ed other than "natural", or Items 23a or 28e-f show event, ibs Medical Examinar must be notified at	Completed	15. Decedent's Educat (Specify only highest grade c Elementary/Secondary (0-12)	con completed) College (1-4or 5+)	(Give	dent's Usual Occu kind of work done DO NOT use retire	during most of work	king		of Business/ind	•	
12 should be filed within h and Mental Hygiene. 7 is marked other than " treumatic event, the Mag	To Be C	17. Father's Name (First, Middle, Last) Preston Allen Stok					Mary 0	liver			
		19a. Informant's Name/Relationship (Type, Jean D. Stokes / Wi	*			street, B					
ent of He nt: If iten ry or oth		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ Rem  4 □ Donation 5 □ Other (Specify)	oval from State	-	sition (Name of natory or other pla Cemeter	4-5-	Date 2005	20c. Loca	ation - City or To	wn, State	
Department of Heali Important: If Item 2 any injury or other once.		21. Signature of Funeral Service Licensee		22	. Name and Addr	ess of FacilityThe Hgts. Ave	Derric	k C.	Jones F/	H, P.A.	
ysician Medical aminer	ler	23a. Part 1. Enter the disease, or complications that called the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, and is leading to immediate cause. Enter Underlying Cause (Disease or injury)  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):									
ohysician and the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d	Due to (or as a conse	equence of):							
led by the attending pt detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	If yes, outcome of pregi 1 ☐ Live birth 2 ☐ Fe 4 ☐ Preg <i>nan</i> t at time of 9 ☐ Unknown	tal death 3	Ectopic pregnanc	у		23	d. Date of deliver	Y Day Year	
en sign	þ	Part II. Other significant conditions contrib	uting to death but not re	esulting in the un	nderlying cause gr	ven in Part I.	23e. Did t		-	e cause of death?	
certificate has be rector, page 2 sho	e Completed	25. Was case referred to medical					performed? death?			sy findings availa pletion of cause of	
n. After this funeral dii	To B	examiner? 1 ☐ Yes 2 No	oital: 1 Impatient 2 [ 28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Inju			dence 6 (	Other (Specify)		
olter in b	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	home, farm, stre	eet, factory, office		28f. Location (S City or Tox	Street and f vn, State)	Number or Rural	Route Number,	
within 24 hours e To the Funeral I completely filled	ledical	29a. Certifier 1 Certifying Physici. (Check only one) 2 Medical Examiner:	an: To the best of my kn On the basis of examin and manner stated.	nowledge, death nation and/or inv	occurred at the ti estigation, in my o	me, date and place, opinion, death occurr	and due to the red at the time,	cause(s) ar date and pl	nd manner as sta ace, and due to	ited. the cause(s)	
To	Σ	29b. Signature and title of certifier	~		29c Licens	e number	4	29d. Date s	signed (Month, D	ay, Year)	
_					P   L	0 (0.)	/	J   6 -	/   ~ /		

STEVEN SALYERS 05-02084 RKD

)			1- For Unpend Item 23a, pt. 11, 27, 2	d / Depa Ba-f p	artment of ler me G8	lealth and M 43 5-5-05 Death	lental Hyg tas	jiene	15	101.33
	•		Decedent's Name (First, Middle, Last)				2. Date of Dea Month	200	Year	3. Time of Death
	Physici /Medic		Steven Salyers				MARCH	23, 20	005	12:29P. <sup>™</sup>
1	Examin	er	4a. Facility Name (If not institution, give street and number)			r Location of Death		4c. County		
1			NORTH ARUNDEL HOSPITAL  5. Social Security Number 6. Sex 7. Age (In yrs. I.	aet histhday)	GLEN B		8. Date of Birth	ANNE A		EL ace (State or Foreign
N.	Funeral Director		5. Social Security Number   6. Sex   7. Age (In yrs. I. 1	• • • • • • • • • • • • • • • • • • • •	Months Days	Hours Min.	Dec. 08	1959	Count	ry) MD
			Usual Residence of Decedent							
	srylan show			r, Town or Lo					10	0d. Inside City Limits 1 ☐ Yes 2 🖔 No
	ith the Marylan or 28a-f show be notified at	Director	Maryland Anne Arundel			sadena	1.	10g. Citizen of V	What Count	
	with t	ä	7787 East Shore Road		10f. Zip Code	21122		•	USA	ny:
	ter death wi	Funeral	11. Marital Status 12. Was Decedent Ever in U.	S. 13. 1	Was Decedent of F	dispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-		e - America	
9	or Ne	T.	Armed Forces?  1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give		if Yes, specify Cub. 1 ☐ Yes 2X No	an, мехісап, Риепо Specify:	Hican, etc.)	Specify	k, White, e	
003	filed within 72 hours after death with the Maryland Hygiene. uther then "naturel", or flems 23a or 28a-f show uther then "naturel", or flems 2a or 28a-f show ant, the Medical Evanti wir must be indiffed at	d by	3 Widowed 4 Divorced Year or Dates:							
15-	n 72 h	iete	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of work	ing	16b. Kind of Bu	usiness/Ind	ustry
12	withi iene. r then	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		Disabled	,			N/A	
Maryland 21215-0036	e filec al Hyg othe vent,	BeC	17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle,	Maiden Surnam	19)	
Var	should be nd Mental marked c	To E	Linal D. Salyers			Virgie	Μ.	Emory		
lan	2 sho and is mu reum		19a. Informant's Name/Relationship (Type, Print)		•	and Number or Run				•
e,	ges 1 and 2 should be filed within 72 hours after death w t of Health and Mental Hygiene. If item 27 is marked other then "naturet", or Items 23e or other treumetic event, The Medical Evanti art final		Richard Salvers (brother)  20a. Method of Disposition 20b. Pl	lace of Dispo	sition (Name of	nore Road,		20c. Location -		
nor	ages nt of it t: If ite		1 X Burial 2 Cremation 3 Bemoval from State	əmetery, crer	matory or other pla en Cemete				•	Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other then 'amy injury or other treumetic event, In In Magone.		21. Signature of Funeral Service Licensee	0.0	N NI Add		-			
B	permi Depa Impo any il		and Xa!		3111 Mour	ntain Road	l, Pasad	èna, MD	<sup>a</sup> 2172	ше, Р.А. 2
	90		23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.	. Do not ent	er the mode of dyin	ng, such as cardiac	or respiratory ar	rest,		Approximate Interval Between
1700	Physician		Immediate Cause (Final disease or condition Airway obstr	uction	by food	bolus				Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequ	ience of):						
	a, '	ъ	Sequentially list conditions, if any, leading to immediate	aence of):						
	uted 5 ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c.							
0,	be executed sician and burial-transit		resulting in death) Last Due to (or as a consequ	sence of):						
8760,	ate be executed hysician and the burial-transi	dicai	d							
9		/Med	IF FEMALE: 230 If you gutterme of progress	nov.						
Вох	that the death certific ed by the attending p detached for use as	sian/	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnant 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3	Ectopic pregnanc	у		23d. Dat	te of delive nth	ry Day Year
P.O.	the de	ysic	1 Yes 2 No 9 Unknown	7411 32						
	Attending Physicien: The law requires that the death certificate to cleath. ector: After this certificate has been signed by the attending p by the funeral director, page 2 should be detached for use as	Completed by Physician/Me	Part II. Other significant conditions contributing to death but not resu	ulting in the u	nderlying cause giv	ven in Part I.	23e. Did to	bacco use conti	ribute to th	e cause of death?
rds	w requires that been signed to should be det	ed b	Down's Syndrome				1 🗆 Y	es 2 No	3 Proba	ably 4 □Unknown
eco	e taw re has be je 2 sho	piet					24a. Was a autop	sy r	Vere autoporior to con	osy findings available appletion of cause of
<u>~</u>	The ate h	Com					perfor	med? 2□No	eath? Yes	2□ No
/ita	ysicien: The tar is certificate has director, page 2	Be	25. Was case referred to medical examiner?  Hospital: Hospital:		0"	26. Place of Deat	Simon of the Property		,	
of	Physic this cral dir	- L	Tares 2 No 1 Impatient 21 N	P/Outpatier 28b. Time o	IL SEL DOA	4   Nursing no	me 5 Resid			)
on	iding F th: After funer	tion	27. Manner of Death  1 Natural 5 Pending 2 X Accident investigation  28a. Date of Injury (Month, Day Year) 3-23-05	Injury	Wo	rk? ]Yes 2 <b>X</b> No	Subject			ood
Division of Vital Records,	after death Director:	ifica	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At ho building, etc. (Specify	me, farm, sti	reet, factory, office		28f. Location (S City or Tow			
Ö	tel or rs afte el Dir	Certification:	Group home				Hanover	, MD		
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical	29a. Certifier (Check only (C							
	thin 2 the or the	Med	and manner stated.  29b. Signature and title of certifier		29c, Licens	se number		29d. Date signed	d (Month, L	Day, Year)
	⊬ ≱ ⊢ ŏ		V & Lords MIN		C	CME	м	ARCH 24	200	5
			30 Name and address of person who completed cause of death (Item	1 23a) (Type,					-1177	
			J. LAKON WICE, MO			enn Stree	t Balt	imore, 1	Mary1	and 21201
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)  MAR 2.8 2005	ture A	seek					

			For Stete Registrer	State of N	Maryland / Depa	artment of H rtificate of L			ene200	0 10434
	Physici	an	1. Decedent's Name (First, Middle,	Last)				2. Date of Death Month	n Day Yeer	3. Time of Death
7	/Medic		Ram P.	Seth				March 2		3:00 P M
	Examin	ner	4a. Facility Name (If not institution,			4b. City, Town, or		h	4c. County of Dec	
			Greater Baltimo		l Center Age (In yrs. last birthday)		WSON If Under 24 Hrs	. 8 Date of Birth	Baltim	
	Funeral Director		212-98-9593	1 M 2 X F	82 Yrs.	Months Days	Hours Min.		Year) 1923	rthplace (State or Foreign country) India
			Usual Residence of Decedent		02					
	rylan how		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Ba-f s	cto	MD Balti	more	Hunt V					1 ☐ Yes 2 No
	or 2	Dire	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	ountry?
	s 23e	Funeral Director	400 Symphony C	ircle Apt		210		Specific Veneralis	USA 14. Race - Am	arigan Indian
	ter de	-un-	11. Marital Status  1 ☐ Never Married 2 ☐ Married	Armed Force	is?	Was Decedent of Hi If Yes, specify Cuba	n, Mexican, Puer	to Rican, etc.)	Black, Wh	
036	urs al	b	3∑ Widowed 4 Divorced	1 ☐ Yes 21 If Yes, Give Year or Date	s:	1 ☐ Yes 2X No	Specify:		Specify:	ian Indian
215-0036	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-1 show the Medical Exarting must be natified at	Completed	15. Decedent's (Specify only highest	Education	16a. Dece	dent's Usual Occupa	ation during most of wa	rkina 1	6b. Kind of Busines	
2	ithin nan "r	npie	Elementary/Secondary (0-12)	College (1-4d	or 5+)	DO NOT use retired	)	9		
121	filed w Hygier Ather th	S	17. Father's Name (First, Middle, La	ect)	F	<u>lousewife</u>	18 Mother's Na	me (First, Middle, M	Own ]	lome
Maryland	2 should be filled within and Mental Hygiene. Is marked other than aumatic event, the Ms	Be	Purshtom Khann	7				i Devi	aluen Sumame)	
Z	should ind Men ind marke i marke	2	19a. Informant's Name/Relationship		19b. Maili	ng Address (Street a		ural Route Number,	City or Town, State,	Zip Code)
$\leq$	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. item 27 is marked other than "natural", or Itams 23e or 28e-f show other traumatic event, The Medical Exertifier must be notified at		Deepak Seth	Son	704	Nicholas	Lane, Co	ockeysvil:	le, MD 210	031
re,	es 1 and 2 of Health fitem 27   r other tra	1	20a. Method of Disposition		20b. Place of Dispo	osition (Name of matory or other plac			0c. Location - City o	
E	Pages nent of I int: If it		1 □ Burial 2 ▼ Cremation 3  '4 □ Donation 5 □ Other (Spe		Carroll (			25/05	Hampstead	d, MD
Baltimore,	permit. Pages Department of Important: If i any injury or o		21. Signature of Femeral Service Li	Censee /		2. Name and Addres	_		Reisterst	
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			23a. Part1. Enter he disease, or conshock, or heart failure. List or	omplications that caus nly one cause on each	sed the death. Do not en h line.				st,	Approximate Interval Between Onset and Death
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8760,	ate be	dicai	•	d						
9	that the death certific ed by the attending p detached for use as I	O .	IF FEMALE:	23c. If yes, outcor	ma of pregnancy				004 000 44	
Вох	attend for us	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live birth	n 2 🗆 Fetal death 3[	☐Ectopic pregnancy ☐ Other (specify)			23d. Date of de Month	Day Year
P.O.	the du y the iched	ysic	1 □ Yes 2 🔼 No 9 □ Unknown	9□ Unknowr						
	The law requires that the death certific the has been signed by the attending prage 2 should be detached for use as		Part II. Other significant condition	s contributing to deat	h but not resulting in the u	inderlying cause give	en in Part I.	23e. Did toba	acco use contribute	to the cause of death?
rds	w requires that s been signed to should be deta	ed k	nyponatre	MIA				1 🗆 Yes	s 2 <b>⊠</b> (No 3 🗆 F	robably 4 DUnknown
of Vital Records,	e taw re has ber je 2 sho	Completed by	diabetes					24a. Was an autopsy	prior to	utopsy findings available completion of cause of
R	The ate h page	Con						perform 1 ☐ Yes 2	ed?   death?	s 2 No
/ita	cian: ertific ector,	Be	25. Was case referred to medical examiner?	Hoseitelt		Oth	261	ath (Check only one		
of	Phya this c	2	1 ☐ Yes 2 ☑ No  27. Manner of Death	Hospital: 1XInpa			4   Nuising i	Home 5 Resider		ecify)
on	ding h. After funer	tion	1 XNatural 5 Pending 2 Accident investiga	(Month,	Day Year) Injury	Work	k? Yes 2 □ No	Ess. BosonBo no	wijary coodirod	
Division	Atten r deat sctor; y the	fica	3 Suicide 6 Could no		Injury - At home, farm, st etc. (Specify)	reet, factory, office		28f. Location (Stre	eet and Number or F	lural Route Number,
Ö	s after s afte	Certification:	4 Homicide	building,	etc. (Specify)			City or Town,	State)	
	To the Hospital or Attending Physician: The twithin 24 hours after death. To the Funeral Director: After this certificate hat bompletely filled in by the funeral director, page	edical (			est of my knowledge, deals s of examination and/or in					
	the hin 24 the F	Medi	one)	and manner	stated.	. , ,				
	5 × 1 × 1		2-50. Signature and title of certifier	melas	MD	D_ N	15981	3	3/25/1	5
<b>,</b>	0		30 Name and address of parson w	no completed Susa	of death (Item 23a) (Type	Print)	00101	10 - (	010010	110
1	1		Laura Donega	M, MD .	0965 N. CV	larles St	# 203	Balt	i rhore,	71 21204
	Sta	ate	29b. Signature and title of certifier  CAUVA  30. Name and address of person w  CAUVA  DOLGA  31. Date filed (Month, Day, Year)  MAR 2 8	2005 3 Reg	istrar's Signature	ede				r
×2	Regist	rar	MHR & O	2000						

Seth, Rom

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Lucille Susie Thomas Slade **Physician** 2005 March 2:15 P M /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George 2322 Brightseat Road #4 Landover | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | October | 9. Birthplece (State or Foreign Country)

3 Washington DC 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 10,1943 577-56-9586 61 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ir than "natural", or items 23a or 28a-f show the Medical Examiner must be ruitified at Yes 2 No Directo Maryland Prince George Landover 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 20785 United States 2322 Brightseat Road #4 Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2XXX If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) United States Coast Elementary/Secondary (0-12) College (1-4or 5+) Twe1th Clerk Typist 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any injury or other traumatic event any injury or other traumatic event ans. 17. Father's Name (First, Middle, Last) Be Therkiel McPherson **Guy Thomas** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2322 Brightseat Road #4, Landover Maryland 20785 Otis C. Slade Sr/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 3-19-05 Riverdale Crematory Riverdale Maryland 22. Name and Address of Facility Robert G. Mason Funeral Home 21. Signature of Funeral Service Licensee 1661 Good Hope Rd SE, Washington DC 20020 23a. Part1. Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** METASTATIC disease or condition resulting in death) /Medical Due to (or as a consequence of): Queeks **Examiner** JERRUMES Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 attending physician Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificete has filled in by the funeral director, page 2 22 No 1 Yes 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funerel L To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner: Do the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 1947603 29d. Date signed (Month, Day, Year) March 9, 2005 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) hellulle Po B316 Bowle, Mis 207/6 31. Date filed (Month, Day, Year) MAR 2.8 2. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b City, Town, or Location of Death 4c. County of Death Examiner 0 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number Date of Birth (Month, Day, **Funeral** Days Min 1□M 2□F Months Hours Director -50-661 Hugust 18,1936 North Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits 10b. County or items 23s or 28e-1 show other treumetic event, the Medical Examiner rust be notified at 1 Yes 2 □ No Completed by Funeral Director more 10e. Stree and Number 10f. Zip Code 10g. Citizen of What Country? Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates: 3 ₩Widowed 4 Divorced "neturei" 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary (Secondary (0-12) and Mental Hygiene. Is marked other then College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Swarmer orui 2 ah 19a. Informant's Na le/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Importent: If item 27 Is eny injury or other tret QDCE. 4310 Cedar Garden Rd. Baito 21209 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State Cemetery \* 4 □ Donation 5 Other (Specify) 01 me and Address of 21. Signature of Funeral Service License Home Balto, MD 21216 North Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due (or as a consequence of): Physician/Medical Examiner for use as the burial-transit MEMIA resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) the a page 2 should be detached 9 Unknown ģ Part II\_Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 4 Onknown 3 Probably 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1 ☐ Yes 25. Was case referre medical

Hose itel or Attending Physicien: The law requires that the death certificate be executed director, this cert funeral After 24 hours after death.

Completed Be

Certification: To in by the pelili

examiner'

1 Yes

27. Manner of Death

1 Natural

2 Accident

3 🗌 Suicide

29a. Certifie

4 T Homicide

(Check only one)

2 No

5 Pending

investigation

6 Could not be determined

Medical within 24 ho To the Fund completely fi

State Registrai

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred Injury at Work?

28c. 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State)

i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

1 Inpatient

28a. Date of Injury (Month, Day Year)

29d. Date signed (Month, Day, Year)

05

31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of pe son who completed cause of death (Item 23a (Type, Prin.)

2 ER/Outpatient 3 DOA

28b. Time of

Injury

		State	State of Maryland	Department of Certificate of			ene N2005	101.27
		Registrar  1. Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death
Physici		Helen Roush Shannon	n			March	Day Year	10:22 AM
/Medic		4a. Fecility Name (If not institution, give stre		4b. City, Town,	or Location of Death		4c. County of Death	
		Scrint AGINES			LTIMOVE		n/a	
Funeral Director		5. Sociat Security Number 6. Sex 1 □ N	7. Age (In yrs. last 96	birthday) If Under 1 Yea Months Day		8. Date of Birth (Month, Day, Y 12/03/1	9. Birth Cou 908 Wash	place (State or Foreign ntry) ington, D.C
<u> </u>		Usual Residence of Decedent  10a. State 10b. County	10c City T	own or Location				10d. tnside City Limits
arylar shov	5							1 ☐ Yes 2√∑ No
the M	ect	Md. Baltimore  10e. Street and Number		tonsville 10f. Zip Code		100	g. Citizen of What Cou	ntry?
death with the Maryland ms 23e or 28a-1 show Frank to notified at	Funeral Director	709 Maiden Choice	Lane	21228	3		USA	
death	ner	11. Marital Status	. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of	f Hispanic Origin? (Spe Jban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White	
aryland 21215-0036 should be filed within 72 hours after death with the Marylan nd Mental Hygiene. I marked other than "naturat", or Items 23s or 28s-f show umatic event, tre Madical Exercities in a fullified at		1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 🔀 N			Specify: W	nite
15-003 n 72 hours n *natural;	Completed by	15. Decedent's Educa (Specify only highest grade of		6a. Decedent's Usual Occ (Give kind of work dor	ne during most of worki		6b. Kind of Business/Ir	ndustry
2121 d within giene. or than	mpie	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use reti	,		Telephon	o Co
id 212. stiled within I Hygiene. other than	S	10 17. Father's Name (First, Middle, Last)	0	Training Sup	18. Mother's Name	(First, Middle, Ma		e w.
and and de filed antal Hyg	o Be	John White			Susie Fe	eukes		
should Me mark	2	19a. Informant's Name/Relationship (Type	, Print)	19b. Mailing Address (Stre	et and Number or Rura	Al Route Number, (	City or Town, State, Zi	p Code)
and 2 ealth ar m 27 is		David Roush / Son		11358 Andrew				
of Hear		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Rei	20b. Plac	e of Disposition (Name of etery, crematory or other p	place)	Date 20	Oc. Location - City or T	own, State
Pages nent of lant. If it		'4 □Donation 5 □ Other (Specify)	Bayv	iew Cremator		/04 Ba	altimore, N	Maryland
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours at Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, tra Madical Event once.		21. Sonal re of Funeral Service Licensee	Len	22. Name and Add	dress of Facility Fi Kens Avenue		uneral Hom ore. Marvl	
Medical Examiner physician and street burial-transit	dicai Examiner	tmmediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d.	Due to (or as a consequent		es '	leeding		17 days
Box 6	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	c. If yes, outcome of pregnanc 1 Live birth 2 Fetal do 4 Pregnant at time of deat 9 Unknown	eath 3 Ectopic pregna			23d. Date of deli Month	very Day Year
cords, P.O. wrequires that the debeen signed by the	d by PI	Part tl. Other significant conditions cont	ributing to death but not resulti	ing in the underlying cause	given in Part I.		acco use contribute to s 2 □ No 3 □ Pro	
Hedes, Hedes, IRecords, The law requires to has been significant page 2 should be	Complete					24a. Was an autopsy perform	prior to c	topsy findings available completion of cause of 2 No
	Be	25. Was case referred to medical examiner?	itali			h Check on one		
of V Of V Of V Physic	ို	1 Yes 2 No			Other: 4 Nursing Ho	ome 5 Resider		ify)
On Con ding F	lon	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury 2 (Month, Day Year)	Injury M	njury at Work? I □ Yes 2 □ No	200. 2000. 20 110.	,,	
Division of Vita Division of Vita I or Attending Physicien: after death. Director: After this certification by the funeral director.	Certification:	2 Accident 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)		се	28f. Location (Str. City or Town,	reet and Number or Ru , State)	ral Route Number,
Division  To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		(Check only 2 Medical Examin	ician: To the best of my knowl er: On the basis of examinatio	iedge, death occurred at the and/or investigation, in n	e time, date and place, ny opinion, death occur	and due to the ca red at the time, da	use(s) and manner as ite and place, and due	stated. to the cause(s)
the Hinn 24	Medical	one) 29b. Signature and title of certifier	and manner stated.	29c. Lio	ense number	29	d. Date signed (Mont)	h, Day, Year)
To To To Con		250. Signature and title of certifier	MD					
•		30. Name and address of person who col	mpleted cause of death (ttem 2		10017			1000
3	tate	31. Date filed (Month, Day, Year) MAR 2 8 20	03 32. Jegistrar's Signatu	o Calon	NVE Ba	mor	e, MU 2	1227
Regis		MAR 2 8 20	US COMMENT IN	7				

State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 2. Dete of Deeth 3. Time of Death Month 7 10 AM **Physician** 2005 3 26 /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth Neme (If not institution, give street end number) Examiner Genesio Eldercan villella finne wither Court If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day. 9. Birthplace (State or Foreign 7. Age (In yrs. lest birthday) 5. Social Security Number **Funeral** Days Mary land Months Yrs. Director Usual Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours effer death with the Meryland Depertment of Health and Mentel Hygiene. Important: If New 27 is marked other than "natural" --- any injury or other traumetic even. 10d. Inside City Limits 10a, Stete 10c. City, Town or Location 1 Yes 2 No Funeral Director Lutherville MD Baltimore 10g. Citizen of Whet Country? 10f. Zip Code 10e. Street and Number USA 21093 806 Dartmoor Road 14. Race - American Indian, . Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11 Maritel Status Black, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 🕅 No Specify: Specify: white Completed by 3 X Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Bethlehem Steel Estimator 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) Ethel Woodroe Satterfield Edward 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informant's Name/Relationship (Type, Print) 10319 Malcolm Circle Apt. B; Cockeysville, MD 21030 David M. Satterfield / son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, cremetory or other pleca) 20a. Method of Disposition 1 Buriel 2 Cremation 3 Removal from State
4 Donetion 5 Other (Specify) entomblient Dulaney Valley Memorial Gardens 3/31/05 Timonium, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 1050 York Road Towson, MD 21204 Ruck Towson Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical Examinet Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed nding physiclen end use es the buriel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, that initiated events Due to (or as e consequence of): resulting in death) Last 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown PHORAL UNSCULAR DISCOLE Completed by 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was en eutopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4☑Nursing Home 5☐ Residence 6☐Other (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 2 No Medical Certification: To 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of injury 28c. Injury at Work? 27. Manne⊮of Death 5 Pending investigation 1 ☑ Naturel efter death.

Director: Aft
d in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours e To the Funeral D 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the bests of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29a. Certifier (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier 26 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) TUNION MD 21204 DAIVE 31. Date filed (Month, Day, Year)
MAR 2 8 2005 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death March 21, 2005 Rose Antoinette Spedalire 3:50 Рм 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Timonium Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year May 25, 1 9. Birthplace (State or Foreign 1□M 201F Months Yrs. 217-26-0748 88 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Baltimore 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13 Tigreff Court 21234 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify: 3 ₩ Widowed 4 Divorced Specify: white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sales Person Department Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pete Livolsi Josephine Romano 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy C. Mirabile daughter 13 Tigreff Court; Baltimore, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 □XBurial 2 □ Cremation 3 □ Removal from State

'4 □ Donation 5 □ Other (Specify) Dulaney Valley Mem Gardens i 3/24/05 Timonium, MD 21. Signature of Funeral Service License 1050 York Road 22. Name and Address of Facility Ruck Towson Funeral Home Towson, MD 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one or use on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CEREBROVASCULAR ACCIDENT Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1∐ Yes 1 ☐ Yes 2 ☐ No 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 NOther (Specify) HOSPICE 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending

**Physician** /Medical **Examiner** 

physician

the

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certificate

After

filled in by

death. after death.

24 hours a

within 2. To the f

that the death certificate be executed

Ö

Records,

Vital

Division of

Physician

/Medical

**Examiner** 

MD

Director

Completed

**Funeral** 

Director

\*how

item 27 is marked other then "neturel" or items 23a or 28e-f shor other treumetic event, the Mudical Examinar must be notified at

Department of Health and Montal Hygiene. Importent: If item 27 is marked other then "ne eny injury or other treumetic event, the Media once.

Baltimore, Maryland 21215-0036

Examine

burial-transit Physician/Medical the use as signed b icate has been sig , page 2 should b Completed director, Be funeral

Certification:

Medical

State Registrar

IF FEMALE 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐ Yes 2X No 27. Manner of Death

2 Accident

4 Homicide

3 ☐ Suicide

investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

TIMONIUM, MD 21093

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physicien: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and manner as stated.

| Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number

29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

05

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. DR. TARIQ MAHMOOD

31. Date filed (Month, Day, Year)

32. Registrar's Signature

MAR 2 8 2005



			- State Amend Item 5,	State of Man 23a per FH	land / Depa Dr, G841	ortment of the care of	lealth and Death	Mental Hyg	giene 1eg. No2 0 0 5	10660
	Physici /Medic		1. Decedent's Name (First, Middle, Las		Smith			2. Date of Dea Month MARCH	Day Year	3. Time of Death
	Examin		4a. Facility Name (If not institution, give Harber 140 ft fac	1 Conter		1 11	oce Mi		4c. County of Deat	1
	Funeral Director		5. Social Security Number 11 6. Sec. 11		n yrs. last birthday) Vrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		Year 38 9. Birth	nplace (State or Foreign untry)  MD
	/aryland f show	or	Usual Residence of Decedent  10a. State 10b. County	A 10	oc. City, Town or Lo	cation.	P)			10d. Inside City Limits 1   Yes 2 □ No
	death with the Maryland ms 23a or 28a-f show critist Lembilling at	Director	10e. Street and Number	's Road		10f. Zip Code	71775	1	10g. Citizen of What Co	untry?
	or Ite	Funeral	11. Marital Status  1 □ Never Married 2 Married	12. Was Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give		Was Decedent of H f Yes, specify Cuba 1 Yes 2 X No	lispanic Origin? (San, Mexican, Puerl	Specify Yes or No- to Rican, etc.)	71	
21215-0036	72 hours after "neturel", or Ite	eted by	3 Widowed 4 Divorced  15. Decedent's Ed (Specify only highest grav	Year or Dates: ucation	16a. Deced	ient's Usual Occup	ation during most of wo	rking	Specify: 5	ndustry
	e filed within al Hygiene. I other than vent, the Mer	Completed	Elementary/Secondary (0-12) 12-14 QVAdL 17. Father's Name (First, Middle, Last)	College (1-4or 5+)	life. I	Homen	naker	me (First, Middle,	- 0,	estic
Maryland	s 1 and 2 should be filed within 72 hours theath and Mental Hygiene. Item 27 is marked other than "neturel", other treumatic event, I'm Medical Eve	To Be	Cliffon Barnes	(man Drink)	105 14-77	Address (Chrost	DoroH	ry Jac	UKSON	
	1 and 2 st Health and Im 27 is n	T	19a. Informant's Name/Relationship (7) Leamon Smith	/Hwband	20b. Place of Dispo	Shellba	walter On	ad Bal	r, City or Town, State, 2 timber MC 20c. Location - City or	21225
Baltimore,	Page nent o ant: If ury or	a de la constanta de la consta	20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐  1 ☐ Quantion 5 ☐ Other (Specify	Removal from State	cometery, crem	natory or other place	103.	21.05	Baltimo	Δ
Bal	permit. Pa Dep rtmer Importent any njury		21. Signalure of Fureral rervice Licent	4		Balti	more Na	TIMAL PIL		eMD 21229
	Pnysician		23a. Part1. Erfer the disease, or comp shock, or hear failure. List only of Immediate Cause (Final disease or condition	ine cause on each line.	te Rei	0	ure	or respiratory arr	est,	Approximate Interval Between Onset and Death
4	/Medical Examiner		resulting in death)  Sequentially list conditions,	Due to (or as a c b. Acute	Respi	ratory	failu	12		4 Days
	be executed ician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Severe Due to (or as a c	Metaboli	c Acidois	<b>.</b>			4 days
8760,	icate be ex physician s the burial	dical E		d.	unasquence or,					
P.O. Box 6	ne death certif the attending hed for use a:	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of particles of the second of the se	Fetal death 3	Ectopic pregnancy Other (specify)	,		23d. Date of deli Month	very Day Year
rds, P.	w requires that the consideration of the considerat	d by Pr	Part II. Other significant conditions co	entributing to death but n	ot resulting in the u	nderlying cause giv	en in Part I.		bacco use contribute to	
Vital Records,	: The law recate has bee	Complete						24a. Was a autops perform	sy prior to a	opsy findings available ompletion of cause of
	ysicien: s certific director,	o Be	25. Was case referred to medical examiner?	Hospital: 1 npatient	2 ER/Outpatien	t 3 DOA Oth	00	ath (Check only on	ence 6 Other (Spec	ifv)
n	Jing After fune	ation; T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yo	ear) 28b. Time of Injury	Wor	y at		ow injury occurred	
Division	To the Hospitel or Attenc within 24 hours after death To the Funerel Director: completely filled in by the	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (.	- At home, farm, str Specify)	eet, factory, office		28f. Location (Si City or Town	treet and Number or Ru n, State)	ral Route Number,
	To the Hospitel or Al within 24 hours after of To the Funerel Direc completely filled in by	edical	29a. Certifier (Check only one) Certifying Physical Example (Check only one)	vsician: To the best of n iner: On the basis of ex and manner stated	amination and/or inv	occurred at the tire vestigation, in my o	ne, date and place pinion, death occu	e, and due to the carred at the time, d	ause(s) and manner as ate and place, and due	stated. to the cause(s)
	To the To the comp	Me	29b. Signature and title of certifier	~	MD	29c. Licens	e number		9d. Date signed (Month	-
	(0)		30. Name and address of person who cos SADEKA SHAH 30015 HANOVER	ompleted cause of deat	h (Item 23a) (Type,	Print) ne, Maryi	iano 212		7	
ľ	Sta Registr		31. Date filed (Month, Day, Year) MAR 2, 8, 2005	32. Registrar's	Signatire	5				

			For State	State of Mary		artment of F			4000	044
			Registrar  1. Decedent's Name (First, Middle	, Last)		timouto or	Doutin	2. Date of Dea	Reg. No.	3. Time of Death
	Physici		RUTH	R.		SCHLOSS		MARCH	23 2005	8:30 P M
4	/Medic Examin		4a. Facility Name (If not institution			4b. City, Town, o	r Location of De		4c. County of Deal	10.00
		Ŭ.	NORTH OAKS HE	ALTH CENTER		PIKESVII	LE.		BALTIMORE	
	Funeral		5. Social Security Number	6. Sex 7. Age (//	In yrs. last birthday)				h 9. Birt	hplace (State or Foreign
	Director		218-32-4541	1□ M 2 📈 F	100 Yrs.			MAR.23	,1905	MD
	and w		Usual Residence of Decedent  10a. State 10b. County	10	Oc. City, Town or Lo	ocation				10d. Inside City Limits
	Manyl 1 sho	ō	MD BA	LTIMORE	PIKI	ESVILLE				1 □ Yes 2 □ No
	28a	rec	10e. Street and Number	ETTIONE	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	10f. Zip Code			10g. Citizen of What Co	ountry?
	filed within 72 hours after death with the Maryland Hygiene. uthar than "natural", or Items 23a or 28a-f show sith, the Medical Esand act must be inclifted at	Funeral Director	725 MT. WILSO	N LANE #216			21208			USA
	deat	ner	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13.	Was Decedent of H	Hispanic Origin?	(Specify Yes or No- erto Rican, etc.)	14. Race - Ame Black, Whit	
ဖွ	after or Ite	/Fu	1 Never Married 2 Marr			1 ☐ Yes 2 💢 No		ono moun, oros,	Specify:	WHITE
21215-0036	ural',	d by	3 X Widowed 4 □ Divorced	Year or Dates:						
5	n 72 l	Completed	15. Decedent (Specify only highes	's Education it grade completed)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of v	vorking	16b. Kind of Business	Industry
7	within ene.	dmc	Elementary/Secondary (0-12)	College (1-4or 5+)		RETARY	_,		NURSING HO	MF
9	filed Hygi othar ant, t	Be Co	17. Father's Name (First, Middle,	Last)	0201	<u> </u>	18. Mother's N	lame (First, Middle,		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Importants if item 27 is marked other than *natural; or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examination at Language.	To B	AARON		ROSE	EN	REBEC	CA		MILLER
ary	shou and N s mai	-	19a. Informant's Name/Relations	nip (Type, Print)	19b. Maili	ng Address (Street	and Number or	Rural Route Numbe	er, City or Town, State, 2	Zip Code)
	and 2 salth a n 27 i		PACY OLETSKY	·			RIDGE D	RIVE - OW	INGS MILLS,	
ore	of He of He fitan roth		20a. Method of Disposition 1 X Burial 2 □ Cremation		20b. Place of Dispo cemetery, cre	osition (Name of matory or other place	ce)	Date	20c. Location - City or	Town, State
<u>Ĕ</u>	Pag ment ant: I ury o		`4 □ Donation 5 □ Other (S	oecify)	ARLINGTO	N CHIZUK	AMUNO 3	/25/2005	BALTIMOR	RE, MD
Baltimore,	permit. Depart Import any inj		21. Signature of Funeral Service	Licensee		2. Name and Addre			SON & BROS.	
_	ă O E ≅ oi		10000/	chu-					PIKESVILLE.	
				only one cause on each line.		ter the mode of dyir			rest,	Approximate Interval Between Onset and Death
	Pnysician		Immediate Cause (Final disease or condition resulting in death)	CONGE	STIVE -	HEMM	FH	TLURE		
	/Medical Examiner		resulting in death)	Due to (or as a c	consequence of):					
		<u></u>	Sequentially list conditions, if any leading to immediate	b	consequence of:					
	ted Insit	nin.	cause. Enter Underlying Cause (Disease or injury							
<u>,</u>	execu n and ial-tra	Examiner	that initiated events resulting in death) Last	Due to (or as a c	consequence of):					
8760,	ate be executed hysician and the burial-transit	ical		d						
9	tifical ng phy as th									
Вох	death certifics e attending ph ed for use as ti	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p		Ectopic pregnancy	у		23d. Date of del	ivery Day Year
O. E.	ne dea the at hed fo	slci	in the past 12 months? 1 ☐ Yes 2 Œ No 9 ☐ Unknown	4☐Pregnant at tim 9☐Unknown	ne of death 5[	Other (specify)			Month	Day real
<u>~</u>	by ac	Ph	Part II. Other significant condition	one contributing to death but I	not reculting in the u	undarhijna causa air	on in Part I	23a Did to	obacco use contribute to	the cause of death?
JS,	signed be det	5	Part II. Other significant condition	mis contributing to death but i	not resulting in the t	indenying cause giv	on in aici.			obably 4 Unknown
Records,	w require been signature	Completed	9					04-146-		
3ec	The law	mpl						24a. Was autop		topsy findings available completion of cause of
		e Co	OF Was asso referred to madical				00 Di(5	1 🗆 Yes	2 No 1 ☐ Yes	2/2 No
Vital	Physician: r this certific ral director,	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No	Hospital: 1   Inpatient	2 ER/Outpatie	nt 30004 Ott		Death (Check only or	lence 6 □Other (Spe	cifu)
of	g Phy er this eral d		27. Manner of Death	28a. Date of Injury (Month, Day Y		-	The Control of the Park	Aut a	now injury occurred	ony)
Division	Attanding r death. actor: After	atlo	Natural 5 Pendin Pendin Pendin	9	(ear) Injury		Yes 2 □ No			
Vis	· Attandi er death. ractor: A by the fu	ific	3 ☐ Suicide 6 ☐ Could determ	not be ined 28e. Place of Injury building, etc. (	- At home, farm, st	reet, factory, office		28f. Location (S City or Tow	Street and Number or Ru	ıral Route Number,
ā	ital or A rs after al Dira ed in by	Certification:		January, Tarana				1		
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical	(Check only 2 Medical	ig Physician: To the best of n Examiner: On the basis of ex	kamination and/or in	h occurred at the til	me, date and pla	ace, and due to the occurred at the time.	cause(s) and manner as	stated. to the cause(s)
	To tha P within 24 To the F complete	Medi	one)	and manner stated	d.	29c. Licens			29d. Date signed (Mont.	
	To To cor	-	29b. Signature and title of certifie	~ / n/	1, 0	29C. LICENTS	2581	1	3/211/20	1, Jay, 1641)
	. 4		Jasuer	who completed as	th /ltorr 22a) T	Print			2	
	V	,	30. Name and address of person	who completed cause of deat	th (Item 23a) (Type,	PARK	HEICE	HT AT	E. RAIT	MA 21200
	Sta	ite	31. Date filed (Month Day, Year)	2005 22. Registrar's		29 -	- 019.	113 11	- / / _ / _ / _ / _ / _ / _ / _ / _ / _	150,00
	Regist		MAK 28	2005 Claves	15- 15-33	ee .				

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 2. Date of Deeth Month 1. Decedent's Name (First, Middle, Last) Day 11:20AM TONY TONALLI, JR. MARCH 22, 4b. City. Town, or Location of Death 4c. County of Deeth 4a Facility Name (If not institution, give street and number) WILLIAMSPORT NURSING HOME WILLIAMSPORT WASHINGTON If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month. Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Days Hours Months t)□ M 2□ F Yrs 88 10/8/1916 WEST VIRGINIA 232-01-8031 Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b County 1√ Yes 2 No MARTINSBURG BERKELFY 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 25401 USA 107 E. MOLER AVENUE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married 1 Yes 2 No WHITE Specify: 3 XWidowed 4 ☐ Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry DuPONT Eiamentary/Secondary (0-12) College (1-4or 5+) CONSTRUCTION/ MAINTENANCE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ANTHONY TONALLI IRENE MAE HENSFLL 19b. Mailing Addrass (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 107 E. MOLER AVE., MARTINSBURG, WV 25401 WINIFRED A. TONALLI/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition MARCH 1 Ø Burial 2 ☐ Cremation 3 ☐ Removal from State MARTINSBURG, WV ROSEDALE CEMETERY 26, 2005 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility BROWN FUNERAL HOME, P.O. BOX 821, 327 W. KING ST., Diano n MARTINSBURG, WV 25402 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final diseese or condition resulting in death) TNEUMONIA Z DAYS Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown HEART FAILURE 24b. Were autopsy findings available prior to completion of cause 24a. Was an autopsy performed?

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

Funeral Director

þ

Completed

Be

**Funeral** 

Director

Department of Heelth and Mental Hygiene.

Important: If item 27 is merked other than "natural, or items 23s or 28s-f ahow any injury or other traumatic event, the Medical Examinet must be notified at pine.

Peges 1 and 2 should be filed within 72 hours aftar death

Baltimore, Maryland 21215-0020

with the Maryland

attending physician and for use as the bunal-transit Certification: To

þ Be Completed

Medicai

State Registrar

Physician/Medical Examiner

or Attanding Physician: The law requiras that the death certificate be executed To the Hospital or Attanding Physic within 24 hours after death.

To the Funeral Director: After this of completely filled in by the funeral dire

Division of Vital Records, P.O. Box 68760.

								1□ Yes	25 <del>5N</del> o	of death? 1 □ Yes	2□ No
25. Was case refer	red to medical				-	26. Place of De	ath (Che	ack only one)	-		
examiner?	No	Hospital: 1 ☐ Inpatient 2 ☐	] ER/Outpatient	OA	Other: 4 Nursing I	Home	ne 5 Residence 6 Other (Specify)				
27. Manner of Deat 1 ⊠Natural 2 ☐ Accident	h 5 🗆 Pending investigation	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	м	28c. I	Injury at Work? 1 □ Yes 2 □ No	28d. [	Describe how i	njury occurred	1	
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined		nome, farm, stree	t, facto	ry, off	ice		ocation (Stree City or Town, Si		or Rural Route I	lumber,
29a. Certifier (Check only one)		hysician: To the best of my kni miner: On the besis of examinated									se(s)

29b. Signature and title of certifier

29c. License number 33707

WILLIAMSPORT.

29d. Date signed (Month, Day, Yeer) March 22, 2005

MD 21795

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HOWE ED E. 31. Date filed (Month, Day, Year)

154 N. ARTIZAN 32. Registrar's Signature

**DHMH 16 Rev 6/95** 

State of Maryland / Department of Health and Mental Hygiene 005 10443 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . 2005 Year March 21, **Physician** Mayrita Helen Tepas 0245 а м /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 5834 Woodwinds Circle Frederick Frederick 7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | May 2, 191 5. Social Security Number 9. Birthplace (State or Foreign Country) New York Funeral 1 □ M 2 🖾 F Director 091-12-4738 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene. snt: if item 27 is marked other than "natural", or items 23a or 28a-f show Lry or other traumatic event, the Medical Examinar must be notified at 10d. Inside City Limits Jacksonville Florida Duval 1 XYes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1649 Avondale Avenue 32205**-**8535 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 should be filed within 72 hours after on and Mental Hygiene. • is marked other than "natural", or iter 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ 3 XWidowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Garvey Andrew Francis Hughes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dr. Joseph J. Tepas III / Son 1649 Avondale Avenue, Jacksonville, FL 32205-8535 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: if any injury or once. Green Lawn Cemetery Mar 24, 2005 Jacksonville, Florida ` 4 ☐ Donation 5 ☐ Other (Specify) <sup>22</sup> Name and Address of Facility
Keeney & Basford P.A. Funeral Home
106 East Church Street, Frederick, MD 21. Signatury of Funeral Service License Kellersan ✓ MOO706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Cerebral Vascular Accident /Medical Due to (or as a consequence of): **Examiner** Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physician and hed for use as the burial-transit law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 4☐Pregnant at time of death 5 Other (specify) ate has been signed by the a page 2 should be detached it 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Advanced Alzheimer's Disease 1 Yes 2 No 3 Probably 4 Unknown Completed Pneumonia 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? 1 Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Sp. Ing) Nursing Home 5 Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA dire 1 ☐ Yes 2 ☑ No this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) llome 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; al or Attending Patter death. 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigating in my opinion and the cause of examiners. 29a. Certifier Medicai Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. To the within 2 To the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 036610 word March 21, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Edward Fisher, M.D., 56 Thomas Johnson Drive, Frederick, Maryland 21702 31. Date filed (Month, Day, Year) MAR 2 8 2005 32. Registrar's Signature Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. U 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year lay tar 5:46A M lon March 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Sinai Baltimore City Hospital of If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 3M 2 F 45 Months Days Hours 214-80-5 **Director** 667 January 26,1960 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "neturel", or Items 23a or 28a-1 shot other treumetic event, the Medical Examinar must be redified at Director 1₽Yes 2□No Baltomore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2150 21223 USA llins Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No þ Specify: 3 ☐ Widowed 4 ☐ Divorced Black Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. Chef Bultimore Convention Ctx Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Taylon S. Spencer William Jennie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ortent: If item 27 is Avenue vette Flowers of Health 423 N. Ellwood Baltmore MD ZIZZY Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State tment of Mt-Carinel Cen. 4 ☐ Donation 5 ☐ Other (Specify) 3/24/05 22. Name and Address Depart Import any in 21. Signature of Funer I Service Licensee Service, P.A. Homore MD 21206-5/05 Bekin Road, Ba 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Staph Anreus Methicillin days /Medical Due to (or as a consequence of): Examiner Peripheral Coquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Be Completed by Physician/Medical Examiner Due to (or as a consequence of): or Attending Physicien: The law requires that the death certificate be executed burial-transit liabetes Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy page 2 should be detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? disease 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No pertension 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? he partitis B 1 ☐ Yes 2 No 1 Yes 2 No within 24 hours after death.

To the Funerel Director: After this certified completely filled in by the funeral director, I 25. Was case referred to medical examiner? 26. Place of Death Check on one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

MAR 28

derson, M.D.
32. Agistrar's Signature

and address of person who completed cause of death (Item 23a) (Type, Print)

. Dinai

	1 - State of Maryland / Department of Health and Mer Certificate of Death	ntal Hygiene 05 10445
Physician /Medical Examiner	2000	Date of Death Month  Day Year  3. Time of Death 1 15 M  4c. County of Death  Raltimore
Funeral Director	ranin ogodie rojerja e-me	Date of Birth (Month, Day, Year) OV. 6 1919  9. Birthplace (State or Foreign Country) Balto., Marylane
Baltimore, Maryland 21215-0036  parmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-1 show any injury or other traumatic event, the Medical Exciter marker rediffical at once.  To Be Completed by Funeral Director	Maryland Baltimore   SSex	Specify: White  16b. Kind of Business/Industry  Crown, Cork & Seal Co.  irst, Middle, Maiden Sumame)  ary Masat  oute Number, City or Town, State, Zip Code)  ryland 21221
7760, te be axecuted be axecuted be burial-transit te burial-transit cal Examiner	21. Signiture of Funeral Service Livensee  22. Name and Address of Facility  1407 Old Eastern Aver  23a. Part Letter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respectively. Immediate Cause (Final disease or condition resulting in death)  23b. Enter university as a consequence of):  22c. Name and Address of Facility  Br  1407 Old Eastern Aver  23c. Name and Address of Facility  Br  1407 Old Eastern Aver  25c. Due to (or as a consequence of):  25c. Due to (or as a consequence of):  25c. Due to (or as a consequence of):  25c. Due to (or as a consequence of):  26c. Due to (or as a consequence of):  27c. Due to (or as a consequence of):	ruzdzinski Funeral Home PA nue Essex Maryland 21221
Is, P.O. Box 68760 res that the death certificate be signed by the attending physician be detached for use as the buri	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23d. Date of delivery  Month Day Year  23e. Did tobacco use contribute to the cause of death?
on of Vital Record  Jing Physician: The law raqui  Atter this certificate has been s  funeral director, page 2 should  ilon; To Be Completed	25. Was case referred to medical examiner?  1	1 Yes 2 No 3 Probably 4 Unknown  24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 2 No 3 Probably 4 Unknown
Divisit  To the Hospital or Attant within 24 hours after death within 24 hours after death to the Funaral Director: To the Funaral Director: Completely filled in by the completely filled in by the Medical Certifical Certificat	29a. Certifier (Check only one)  2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a and manner stated.  29b. Signature and title of certifier  29c. License number  29c. License number  30. Name, and address of person who completed cause of death (Item 23a) (Type, Print)  31. Date filed (Month, Day, Year)  32. Registrar's Signature  MAR 2 8 2005	due to the cause(s) and manner as stated.  It the time, date and place, and due to the cause(s)  29d. Date signed (Month, Day, Year)  March 25 2005  TUE, Baltimore, MD, 31337

			Ticuse I	State of Maryland / D	epartment of Health	-	•	
			1 - For State Registrar	•	Certificate of Deat	4	1. No.2 11 11 5	101.1.6
н	Physici	an	1. Decedent's Name (First, Middle, Last)	1 / .		2. Date of Death Month	Day Year	3. Time of Death
	/Medi		Elemay	Wishon		MARCH	22 200S	
	Examir	ner	4a. Facility Name (If not institution, give:		4b. City, Town, or Location	n of Death	4c. County of Death Baltimo	
	Funeral		5. Social Security Number 6. Sex	Re CNFCR 7. Age (In yrs. last birth		er 24 Hrs. 8. Date of Birth		
	Funeral Director			1 M - 1	rs. Months Days Hours	s Min. (Month, Day, Y		place (State or Foreign ntry) ginia
	p ,		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town		02110-11		
	shov ed at	'n	20 116					10d. Inside City Limits 1 ☐ Yes 2 No
	h the Maryland r 28a-f show	Director	MD Ba(+) mo	re Balti	10f. Zip Code	100	g. Citizen of What Cou	- ' )
	death with the Maryland ms 23a or 28a-f show rmust be notified at	0	1 Eastern BIVD	Essex MD	21221		USA	,.
	Items 2	Funeral		12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic C If Yes, specify Cuban, Mexic	Origin? (Specify Yes or No-	14. Race - Amer	
õ	to o		1 Never Married 2 Married	1 Yes 2 No	1 ☐ Yes 2 No Special		Specify: White	etc.
2-003p	hours tural', o	d by	3 Widowed 4 □ Divorced	Year or Dates:				
7	within 72 ene. than "nat	olete	15. Decedent's Edu (Specify only highest grade	e completed)	Decedent's Usual Occupation (Give kind of work done during m life_ DO NOT use retired)	ost of working	6b. Kind of Business/Ir	•
7 7	d with giene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	ille DO NOT use retired) ales Person		Departme	ntStore
<u> </u>	e files al Hyg I othe vent,	Be C	17. Father's Name (First, Middle, Last)		18. Mo	ther's Name (First, Middle, Ma	aiden Sumame)	
ylan	Ments Ments arked arice	To E	Joseph Freder	ick	I	Florence Pri	.ce	
Jar	12 short and rismuration		19a. Informant's Name/Relationship (Ty		Mailing Address (Street and Num			
a,	s 1 and f Health item 27 other to		Celia J. Gray		04 Delaware A Disposition (Name of		ore MD 21  Oc. Location - City or T	
9	ages ont of t: If it y or o		1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	lemoval from State cemetery	r, crematory`or other place) HillCemetery		Baltimor	
Baitimo	nit. Partme ortan injur		21. Signature of Funeral Service Licens	_	22. Name and Address of Fac	cility	_	
ă	Dep den gany		1. Tierry	omully	300Mace A	ConnellyF Ave. Baltimo		
			23a. Part1. Enter the disease shock, or heart failure. List only or	ications that caused the death. Do no	ot enter the mode of dying, such a	as cardiac or respiratory arres	1	Approximate Interval Between
•	Physician		Immediate Cause (Final disease or condition	Atherope		Henry a		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence of			Ch 635	
		ē.	Sa uentially list conditions if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of	1):			
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events		,			
o,	ate be executed hysician and he burial-transit		resulting in death) Last	Due to (or as a consequence of	f):			-
2/00	ate be hysicia he bu	lcaf		1		<u> </u>		
200	leath certificat attending phy I for use as th	Med	IF FEMALE:	• *			1	
מסא	death or e attend id for us	lan/Me	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnancy  1 ☐ Live birth 2 ☐ Fetal death	3 Ectopic pregnancy		23d. Date of deliv Month	ery Day Year
j.	o e	Physicia	1 ☐ Yes 2 ₩No 9 ☐ Unknown	4☐ Pregnant at time of death 9☐ Unknown	5 Other (specify)			
ŗ	w requires that the been signed by the should be detach	by Pr	Part II. Other significant conditions cor	ntributing to death but not resulting in	the underlying cause given in Par	rt I. 23e. Did toba	cco use contribute to t	he cause of death?
	quire:		Advances	1 Demont	ia ,	1 🗆 Yes	2 □ No 3 □ Pro	bably 4 Dunknown
Hecords	The law requires that ite has been signed b vage 2 should be deta	ompleted	Parkins	n's dise	ze:	24a. Was an autopsy	24b. Were auto	opsy findings available empletion of cause of
Ē		Com	·			performe	d? death?	
Vitai	Physician: The law this certificate has b al director, page 2 s	Be (	25. Was case referred to medical examiner?	11-1	0.1	ice of Death (Check only one)		
5	this ald	- T	1 ☐ Yes 2 ☑ No  27. Manner of Death	fospital: 1 ☐ Inpatient 2 ☐ ER/Outp 28a. Date of Injury 28b. Ti		Nursing Home 5 ☐ Residence 28d. Describe how		(y)
0	ding th. After funer	tion	1\□Natural 5 □ Pending 2 □ Accident investigation		jury Work? M 1 ☐ Yes 2 [	_	injury occurred	
VISION	el or Attending F s after death. Il Director: After Id in by the funera	ertification:	3 Suicide 6 Could not be	28e. Place of Injury - At home, fare	m, street, factory, office		et and Number or Run	al Route Number,
5	spitel or At ours after o heral Direct filled in by	Cert	4 _ nomicide	building, etc. (Specify)		City or Town,	State)	
	To the Hospitel or A within 24 hours after To the Funeral Dire completely filled in b	edicai	(Check only 2 Medical Examin	sician: To the best of my knowledge, ner: On the basis of examination and	death occurred at the time, date	and place, and due to the causeath occurred at the time, date	se(s) and manner as s	tated.
	within 2 To the complet	Med	one) 29b. Signature and title of certifier	and manner stated.	29c. License numbe		I. Date signed (Month,	
	Z . M Z 8		M-D		D-35	7754 E	03-23-	2005
	1.0		30. Name and address of person who co	mpleted cause of death (Item 23a) (	Type, Print)	3754 C RN BLUD	4.0	D (2 2 1
_	10			WASBEM, =	709. EASTE	RN BLUD	, MD-	21221.
:	Sta	ite .	31. Date filed (MAR 2 8 2005	32. Registrar's Signature	handle o			

			1 - For State Ragistrar	State of	Marylan	d / Depa		t of H	ealth a	and M	lental Hy			10447
	Physici /Medio		1. Decedent's Name (First, Middle, to James Wilson We	,							2. Date of De Month March		05 <sup>Year</sup>	3. Time of Death 9:05A M
}	Examir		4a. Facility Name (If not institution, g Frederick Vill		oer)				Location o	of Death			unty of Death Baltimo	·
	Funeral Director		5. Social Security Number 220-01-5398  Usual Residence of Decedent	Sex 7. 1 ← M 2 □ F	Age (In yrs. )	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da 1/3/19	th ay, Year) 120	9. Birthp Cour Mary	lace (State or Foreign tty) Land
	Maryland -1 show lied at	tor	10a. State 10b. County MD Howard			y, Town or Lo		у					1	0d. Inside City Limits 1 ☐ Yes ※※No
	h with the 23a or 28a st be neti	Funeral Director	10e. Street and Number 3817 Plum Sprin	g Lane			10f. Zip	Code 21042	2				of What Cour	ntry?
036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23s or 28s-f show aumatic event, if e Modical Exp. ciriett. ust be notified at	þ	11. Marital Status  1 ☐ Never Married 2  Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Deceded Armed Force 1 X Yes 2 If Yes, Give Year or Date	es? □ No		Was Deced f Yes, spec	ify Cubar	spanic Origin, Mexican	gin? (Spe i, Puerto	ocify Yes or No Rican, etc.)		Race - Americ Black, White, ecily: Whi	etc.
Maryland 21215-0036	I within 72 ho liene. r than "natur tre Modical	Completed	15. Decedent's (Specify only highest g Elementary/Secondary (0-12)		lor 5+)		lent's Usua kind of wor DO NOT us	k done d e retired)	u <i>ri</i> ng most	t of worki	ng		of Business/Ind	,
yland	ould be filed Mental Hyg arkad othar atic evant,	To Be C	17. Father's Name (First, Middle, Las Gabriel S. Webs						Add	ie D	(First, Middle,			
	and 2 sho salth and n 27 is ma		19a. Informant's Name/Relationship Mary DeManss	(Type, Print)		3817	Plum	Spri	ing L	or or Rura ane	/Route Numb Ellicot	er, City or To	wn, State, Zip MD.	21042
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is markad any injury or othar traumatic ev		20a. Method of Disposition  1X Burial 2 ☐ Cremation 3  '4 ☐ Donation 5 ☐ Other (Spec  21. Signature of Funeral engage Lic	eify)	a.e		Memo	rial d Address	L 3	/22/ y Mi		Baltin Lppel 1	Funeral	Maryland Home Inc.
09/89	death certificate be executed  Wedjecal  e attending physician and for use as the burial-transit	dical Examiner	23f. Part1. Entey fig disease, or concook, or year failure. List online diate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	as a consequence as a c	uence of):	er the mode			cardiac o	r respiratory a	rrest,		Approximate Interval Between Onset and Death
C. BOX	the death certifica y the attending ph tched for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		n 2 ∏Fetal It at time of de	death 3	Ectopic pre Other (spe					23d.	Date of delive Month	ry Day Year
ecords, P	law requires that the de as been signed by the a 2 should be detached t	by	Part II. Other significant conditions	contributing to deat	th but not resu	ulting in the un	derlying ca	iuse givei	n in Part I.			obacco use c		e cause of death?
Vital Reco	The ate his page	e Completed	OF West and the second							<del>.</del>	1 Tes	rmed?	prior to con death?	esy findings available apletion of cause of
10 U	fter ti	ertification: To Be	25. Was case referred to medical examiner?  1   Yes   No  27. Manner of Death   Natural   5   Pending investigation			ER/Outpatient 28b. Time of Injury		Other	Nur	rsing Hom 2	Check on one 5 Resident Reside	dence 6 🗆		)
DIVISION	To tha Hospital or Attandi within 24 hours after death. To tha Funaral Diractor: A completely filled in by the fu	OI	3 Suicide 6 Could not determined	286. Place of	Injury - At ho , etc. (Specify	me, farm, stre	et, factory,	office		2	8f. Location (5 City or Tow		mber or Rural	Route Number,
	tha Hospi in 24 hou tha Funar ipletely fill	ledical	29a. Certifier Cartifying P (Check only one)	hysician: To the be minar: On the basi and manner	s of examinat	wledge, death ion and/or inv	estigation,	in my opi	nion, deatl	d place, a h occurre	nd due to the d d at the time, d	cause(s) and date and plac	manner as sta e, and due to	ated. the cause(s)
	t with	Σ	29b. Signature and title of certifier	OX PM	dend	long polie			1037			3	ned (Month, E	
	10		30. Name and address of person with	edeni	Me Ro	15	Print)	05	C	An	sille	e Mr	7212	28
	Sta Registr		31. Date filed (Month Pay, Year) 2	005 32 Reg	istrar's Signat	ure Jos	de							

			For State Registra <b>mend item</b>	State of M		•				and M	ental Hy	/giene Reg. Na	2005	10449
	Physicia /Medic		1. Decedent's Name <i>(First, Middle, La</i> Adrianne Elizabe	St)							2. Date of D Month March	Da	<sup>y</sup> 2005	3. Time of Death 12:30 P
	Examin		4a. Facility Name (If not institution, given	e street and number	r)		4b. City,	Town, or	Location o	f Death		4c.	County of Dea	th
			14566 Blythwood L				Burt			0414== 1			ntgomer	-
	Funeral Director		5. Social Security <b>1503</b> 241-62-1510  Usual Residence of Decedent	Sex 7. A	66	last birthday) Yrs.	If Under Months	Days	If Under a	Min.	8. Date of B (Month, D	1938 1938	C	thplace (State or Foreigountry) th Carolina
	anytand show	_	10a. State 10b. County	<b>*</b> 17		y, Town or Lo								10d. Inside City Limits
	289-f	ecto	MD Montgome	Ly	Dul		10f. Zip	Code				10g Cit	izen of What C	ountry?
	with 3a or	ā	14566 Blythwood L	ane			208					-	.S.A.	,
036	be filed within 72 hours after death with the Maryland hat Hygiene ed other than "natural", or Itema 23a or 28e-f show event, the Medical Franciar must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 X Married 3 Widowed 4 Divorced	12. Was Deceder Armed Forces 1  Yes 2 2 If Yes, Give Year or Dates	No No	i	Was Deced f Yes, spec		spanic Orig n, Mexican Specify:	gin? (Spe i, Puerto F	cify Yes or N Rican, etc.)	0-	14. Race - Am Black, Whi	te, etc.
9500-61212	athin 72 ho ne. han "natur e Meulcel	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-40	r 5+)	life. l	kind of wo DO NOT us	rk done c	turina most	t of workir	ng		and of Business	•
N	filed w Hygier other tl		12 17. Father's Name (First, Middle, Las.	-)		Secre	tary		18 Mothe	r's Name	(First, Middle			overnment
au	ould be f Mental I arked of	o Be	Joe C. Wilkey	,							Holscl			
Maryland	2 should be and Mental Is marked a aumatic ev	F	19a. Informant's Name/Relationship	Type, Print)		19b. Mailir	ng Address	(Street a	and Numbe	er or Rura	l Route Num	ber, City o	or Town, State,	Zip Code)
Ž	alth a		Howard Abernethy	, Husband		14566	Blyt	hwoo	d Lan	e, B	urtons	vill	e, Mary	land 20866
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Monla Importent: If item 27 is marked any injury or other traumatic as once.		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 X 14 □ Donation 5 □ Other (Speci		9 0	Place of Dispo emetery, crem inklin	natory or o	ther plac			ate /2005		ocation - City or Lsboro,	
Balti	permit. Departn Importe any Inju		21. Signature of Furnital Service Lice	nsee (		1000000				CONTRACTOR OF	ole Tr , Rock			land 20852
	Physician		23a. P. rt1. Enter the dis-se, or con- shock, or heart failus. List only Immediate Cause (Final disease or condition	plications that canso one cause on each			er the mod	le of dyin	g, such as	cardiac o	r respiratory	arrest,		Approximate Interval Between Onset and Death Immediate
6	/Medical		resulting in death)	Due to (or a										
	Examiner		Sequentially list conditions, if any, leading to immediate	b. Widely			ed br	east	canc	er				10 years
	ed sit	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	is a conseq	uence of):								
8/60,	ate be executed hysician and the burial-transit	ical Examiner	that initiated events resulting in death) Last	c. Due to (or a	is a conseq	uence of):								
8	physic physic the b	dica		_ d										
O. Box 6	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 ☐ Feta at time of d	Ideath 3□	Ectopic pi Other (sp						23d. Date of de Month	olivery Day Year
7.	luires that t n signed by ild be detac	by	Part II. Other significant conditions	contributing to death	but not res	ulting in the u	nderlying o	ause givi	en in Part I.			_		o the cause of death?
Vital Hecords,	The law requir ste has been s paga 2 should	Completed				<u></u>					24a. Wa auto per 1 \( \text{Yes}	opsy formad?	prior to	utopsy findings availabl completion of cause of
Ita		BeC	25. Was case referred to medical examiner?						26. Place	of Death	(Check only			
0	Physician: this certificant all director,	To	1 □ Yes 2 🛣 No	Hospital: 1 ☐ Inpa		ER/Outpatier							6 □Other (Spe	acify)
	ding Ph th. After th funeral	on:	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Ir (Month, L	ijury Day Year)	28b. Time of Injury		28c. Injun Worl			28d. Describe	how inju	ry occurred	
Division	or Atten fter dea Director in by the	Certification	2 Accident investigation 3 Suicide 6 Could not determined	e 28s Floor of I	njury - At ho etc. <i>(Specif</i>	ome, farm, str y)	M reet, factor		Yes 2 □1			(Street ar own, State		ural Route Number,
_	Hospite 4 hours Funeral tely filled	edicai Ce	29a. Certifier 1	hysician: To the besing and manner	of examina	owledge, death ation and/or in	h occurred vestigation	at the tin	ne, date an pinion, dea	d place, a	and due to the	e cause(s o, date and	) and manner a d place, and du	s stated. e to the cause(s)
	To the within 2 To the comple	Me	29 <del>b. Signature</del> and title of certifier	1	) u	2	-		2286	7			te signed (Mon	
	L		30. Name and address of person who				Print)							
			Edward P. Gelman						.W. W	ashi	ngton,	DC 2	20007	
	Sta Regista		31. Date filed (Month, Day, Year)  MAR 1 4	32. jegis	strar's Signa	the A	edi	)						

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of I	Maryland		artment rtificate				/lental Hy	giene	05	10450
			1. Decedent's Name (First, Middle,	Last)							2. Date of Dea	ath		3. Time of Death
	Physic /Medi		BARRY NEAL ALSU	JP							Month MARCH	Day 1 2	Year 2005	5:50 p <sup>M</sup>
}	Exami		4a. Facility Name (If not institution,	give street and number	er)		4b. City, T	own, or	Location	of Death	Innon		ounty of Death	J.30 P
			St Mary's Hospi	ital			Leon	ard	+own			S+	Marys	
	Funeral			6. Sex 7.	Age (In yrs. I	ast birthday)	If Under 1		If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da	h ( Year)	9. Birthp	lace (State or Foreign
	Director		282-56-0963	1 □ M 2 □ F	50	Yrs.	MOTHERS	Days	Tiours	IVIII I.	NOV 9 1	954	Georg	
	pu s		Usual Residence of Decedent  10a. State 10b. County		10c City	, Town or Lo	cation							04 (14-0) (11-1
	sho	5	Maryland St Mar	v's		chanics		ı					'	0d. Inside City Limits 1 X Yes 2 □ No
	28a-1	ect	10e. Street and Number	1								10- 0:4:		
	with B or	ä	29911 Skyview Dr	rizro			10f. Zip (					10g. Citizer USA	n of What Coun	itry?
	eath	Funeral Director	11. Marital Status	12. Was Decede	nt Ever in LLS	S 13 1			annia Ori	iain2 (Ca	ecify Yes or No-		Race - Americ	no ladina
	ter d	Ë	1 ☐ Never Married 2 ☐ Marrie	Armed Force	s?		f Yes, specif	y Cubar	n, Mexica	n, Puerto	Rican, etc.)	14.	Black, White,	
336	urs af	þ	3 Widowed 4 Divorced	If Yes, Give Year or Date	_		I□Yes 2	XNo	Specify:			Sp	ecify: W	Mhite
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-f show te M. alcal Ex., niner: wat be rediffed at	Completed	15. Decedent's			16a. Deced	lent's Usual	Оссира	tion			16b. Kind	of Business/Inc	ustry
215	hin 7	pie	(Specify only highest Elementary/Secondary (0-12)	College (1-4c	or 5+)	(Give life. L	kind of work OO NOT use	done d retired)	uring mos	it of work	ring			ŕ
21	filed within Hygiene. other than ant, it e M	on	12	00090(1.40		Heavy	/ Epui	pmer	nt Op	erat	cor	Scra	p Indus	stry
pu	be filed within 72 hours after death with the Marylan ital Hygiene. ad other than "natural; or itams 23a or 28a-f show event, Ite Marical Examinetr and be notified at	Be (	17. Father's Name (First, Middle, L.	ast)					18. Mothe	er's Nam	e (First, Middle,	Maiden Su	mame)	
<u>/la</u>	should be filed within od Mental Hygiene. marked other than matic evant, It's M	70	Bill Alsup						Bark	bara	Studsti	11 A1	sup	
Maryland	0 6 8 E		19a. Informant's Name/Relationshi	ip (Туре, Print)		19b. Mailin	g Address (	Street a	nd Numbe	er or Rur	al Route Numbe	r, City or To	own, State, Zip	Code)
	D = 2 = -	1 9	Tina Marie Alsu	up (wife)					Driv	re Me	echanics	ville	, MD 20	0659
ore	iges 1 ar of Hea if item?	li i	20a. Method of Disposition	3 □Removal from Sta	ce	ace of Dispos metery, cren	natory`or oth	er place			Date		ion - City or To	
Ĕ	Par Jan		t	ecify)	Mar	cyland	veter	ans	Cem	3–:	17-05	Che1	tenham,	MD
Baltimore,	permit. Pages Department of Important: If it any injury or c		21. Sig lattire of Furieral Service Li	icensee MC	00173	10	. Name and			EDE	erwein F			
			23a Part1. Enter the disease, or c	Complications that cause	ad the death		133 Wh	ite	P1a	L. Lā	. White	Pls.	, MD 20	
B			shock, or heart failure. List o	nly one cause on each	n line.	. Do not ente	er the mode	or dyling	, such as	cardiac	or respiratory an	est,		Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	_a	nock									Day-Hours
	Examiner				as a consequ	,	0.10		0		i i			40415
		<u></u>	Sequentially list conditions,	0.	as a consequ		017	10	251	168	e He-	MO 53	rage !	10
	ted nsit	nin	cause. Enter Underlying Cause (Disease or injury that initiated events	Cul			r. F	/ .	1.0	7	houns		2001	4 racs
	and and al-tra	Examiner	that initiated events resulting in death) Last	c. Due to (or a	as a consequ			CI	7 64		-10041003	(7)01	7(1))	
8760,	The law requires that the death certificate be executed tite has been signed by the attending physician and bage 2 should be detached for use as the burial-transit				covol		(ndi	2n C	-					40015
687	icate phys s the	edicai		d. / ) [ (	0 0 1									
Вох	eath certifi attending p for use as	/We	IF FEMALE:	23c. If yes, outcon	ne of pregnar	ncv						224	. Date of deliver	
B	atter I for u	Physician/M	23b. Was decedent pregnant in the past 12 months?		2 Fetal	death 3	Ectopic pred					230.		ry Day Year
РО	at the de by the itached	iysi	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown			Other (spec	·''y/						
0	that led by deta		Part II. Other significant condition	s contributing to death	n but not resul	Iting in the un	iderlying cau	ise givei	n in Part I.		23e. Did to	bacco use	contribute to the	e cause of death?
g	uires sign Id be	d by									1 □ Y	es 2 🗆 N	io 3∏Proba	ably 4 Unknown
ecord	w require been sig should b	Completed									24a. Was a	2	4b More sutan	osy findings available
Re	The farate has page 2	m									autop	SV	prior to com death?	apletion of cause of
g		e Co	OF Was seen referred to medical									2 No	1 🗆 Yes	2 🗆 No
Division of Vital	00 00 E	o Be	25. Was case referred to medical examiner?  1 \( \subseteq \text{Yes} \) 2 \( \subseteq \text{No} \)	Hospital:				Othor	_		Check only or			
of	Phys r this ral di	F	1 Yes 2 No 27. Manner of Death	28a. Date of Ir		R/Outpatient 28b. Time of	The second second	: Injury	4 🗀 Nu		me 5 Residence 128d. Describe he			)
on	ding f h. After funer	tion	1 Natural 5 ☐ Pending	(Month, L	Day Year)	Injury	м	Work'	?` es 2 □1		204. 104301104 11	JW IIIJaiy Oc	Zuried	
Si	tten deal tor: the	fica	3 Suicide 6 Could no	ot be	Injury - At hor	me farm stre				-	28f. Location (S.	treet and N	umber or Bural	Pouta Number
Δ	lor A after Dira	Certification;	4 ☐ Homicide determin	building,	etc. (Specify)	)	ot, ractory, t	Jillo			City or Town		umber of Aurai	House Warnber,
	Hospital 24 hours a Funaral itely filled		29a. Certifier	Physician: To the bes	st of my know	viedne death	occurred at	the time	date an	d nlace	and due to the c	auso(s) and	I mannor as sta	atod
	To the Hospital or Al within 24 hours after of To tha Funaral Dirac completely filled in by	edical	(Check only 2 Medical Ex	xaminer: On the basis and manner	of examination	on and/or inv	estigation, in	my opi	nion, dea	th occurr	ed at the time, d	ate and pla	ce, and due to	the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier				29c. l	icense	number		2	9d. Date si	gned (Month, E	Day, Year)
}			Danavio				10	006	191	7			3-14-0	5
(			30. Name and address of person wi	ho completed cause of	f death (Item :	23a) (Type. F								
1	B		DHANANJAY V BHA		AH ASS			D M	D 20	636				
	Sta	te	31. Date filed (Month, Day, Year)	32. Regis	strar's Signatu		111 1100.		.20	000				
	Registr	ar	MAR 1 5	2005	Select 1	& do	all's							

		ľ	State Registrar	of Maryland / [	Departmer Certifica				Re	g. No. U	15	10451
	Physici: /Medic		Decedent's Name (First, Middle, Last)     Helen M	. Adams					2. Date of Death Month	Day 13	Year 05	3. Time of Death
	Examin		4a. Facility Name (If not institution, give street and a Millennium Nursing & Re	hab	E	llico	Location of Ott Ci	ty			ward	
	Funeral Director		5. Social Security Number  055 14 7405  059 1	7. Age (In yrs. last bin	Yrs. If Under	Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day, July 6,	1914	9. Birthp Cour New	elace (State or Foreign etry) 7 York
	ne Maryland 8a-f show pulled al	ector	10a. State 10b. County MD Howard	10c. City, Town	mbia							0d. Inside City Limits 1 ☐ Yes 2 XNo
	In with II	al Dire	10e. Street and Number 7070 Cradlerock Way #20	7		1045			10	g. Citizen of Unite		•
220	d withn 72 hours aller death with the Maryland sjene. sjene, rthan *natural', or Items 23a or 28a-f show the Madical Examiner must be notified at	by Funeral Director	Armed	cedent Ever in U.S. Forces? s 2⊠No Give Dates:	13. Was Dece If Yes, spo		spanic Origi n, Mexican, Specify:	in? (Spec Puerto P	cify Yes or No- lican, etc.)		ce - Americ ck, White, fy: Wh	
2	d within 72 jiene. r than "na Ire Medic	Completed	15. Decedent's Education (Specify only highest grade complete  Elementary/Secondary (0-12)  College 12	(1-4or 5+)	Decedent's Usi (Give kind of w life. DO NOT (	ork done d ise retired	during most ( )	of workin	g 1	Sb. Kind of B		dustry
2	be file ta! Hyg d othe event,	To Be C	17. Father's Name (First, Middle, Last) Charles Adams				18. Mother Estel		(First, Middle, Mi			
Mai	0)		19a. Informant's Name/Relationship (Type, Print) David B. Adler/Son						Route Number,			
Dalilliore,	Pages 1 and 2 nent of Health a ant: If item 27 Is ary or other tra		20a. Method of Disposition  1 Burial 22 Cremation 3 Removal fro  4 Donation 5 Other (Specify)	20b. Place of cemeter	Disposition (Nary, crematory or	me of other place	е)	Da	ate 2	Catons	- City or To	wn, State
	permit. Pages Department of It Important: If its any injury or of		21. Signature of Funeral Service Licensee	M01044					y H. Wit	zke's	Fami	ly FH Inc. MD 21043
	nysician /Medical Examiner		23a. Pant. Enter the disease, or complications the shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	daused the death. Do neach line.	CA	de of dying	0	ardiac or	respiratory arres	et.		Approximate Interval Between Onset and Death
,	ale be executed hysician and he burial-transit	I Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c.	o (or as a consequence o								
-	ing physi	Medical	d									
	rnal rne dearn cerrinica ed by the attending ph detached for use as th	Physician/Med	23b. Was decedent pregnant 1 Live	outcome of pregnancy birth 2 Fetal death gnant at time of death known	3 □Ectopic p 5 □ Other (s						te of delive onth	ry Day Year
1 (2)	v requires that been signed I should be det	by	Part II. Other significant conditions contributing to	death but not resulting in	n the underlying	cause give	en in Part I.				tribute to th	e cause of death?
	ate has	Completed							24a. Was an autopsy performe 1 Yes 24	od?	prior to cor death?	osy findings available inpletion of cause of
	tending Physician: In leath. tor: After this certificate the funeral director, pag	ion; To Be	27. Manner of Death 28a. Dar		ime of	28c. Injury Work	at	sing Hom 28	(Check only one) e 5 Residen 3d. Describe how	ce 6 Oth	, , ,	")
	at or Attending after death. I Director: After d in by the fune	Certification;		ce of Injury - At home, fai ding, etc. (Specify)	rm, street, factor		∕es 2∐No		8f. Location (Stre City or Town,		per or Rura	l Route Number,
	within 24 hours after of To the Funeral Direct completely filled in by	edical	29a. Certifier (Check only one) Certifying Physician: To the 2 Medical Examiner: On the and mi	he best of my knowledge basis of examination and inner stated.	dor investigation	at the tim	e, date and inion, death	place, ar	nd due to the cau d at the time, dat	se(s) and ma e and place,	anner as st and due to	ated. the cause(s)
,	,	2	29b. Signature had title of certifier	ullan	~	License	number 855	· · ·	290	3 $14$	d (Month, I	Day, Year)
0		ta	30 Name and address of person who completed can be seen as a seen	use of death (Item 23a) (	(Type, Print)	) BRK	1)	ELCI	OHIS A	YE 1	2000	12 MD2126
	Sta Registr		MAR 1 5 2005	Glen G.	Anne	1						

ORIGINAL

	1	For State Registrar 3–18–0	5Amend#18.Per	ryland/Deparent	artment of He rtificate of D	ealth and M Death	, ,	ne .2005	10452
t. Physicia		Decedent's Name (First, Mid	die, Last)				2. Date of Death Month	Day Yeer	3. Time of Death
/Medica	al .	TED	BOCKARI	E			MARCH	7 2005	6:45 A
Examine	∋r	4a. Facility Name (If not instituti			4b. City, Town, or L			4c. County of De	
uneral		8201 Landove 5. Social Security Number		(In yrs. last birthday)	Landove	If Under 24 Hrs.	8 Date of Righ	Prince (	
irector		579-13-2068 Usuel Residence of Decedent	1XIM 217 F	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Y May 30 1	961 Sie	rthplace (State or Foreig Country) erra Leone
ust be notified at	ctor	MD Prin	ce George's	10c. City, Town or Lo Lar	adover				10d. Inside City Limit 1X Yes 2 □ N
De no	Dire	10e. Street and Number			10f. Zip Code		10g	. Citizen of What C	ountry?
	al a	8201 Landover			20785			U.S.A.	
9	by Fur	11. Marital Status  1 □ Never Married 2 ☑ Ma  3 □ Widowed 4 □ Divorce	If Yes Give		Was Decedent of Hisp f Yes, specify Cuban, 1 ☐ Yes 2☑ No		cify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify: R1	
in "naturel",	Completed		ent's Education est grade completed)  College (1-4or 5+)	(Give	dent's Usual Occupati kind of work done du DO NOT use retired)	ion ring most of worki	ng 16	o. Kind of Business	
er tha	EO	Contentary/Secondary (0*12)	5+		sician			Private	<b>5</b>
marked other than matic event, In Ma	Be	17. Father's Name (First, Middle		•	1.	8. Mother's Name	(First, Middle, Mai	den Sumame)	
arke	0	Todd Bockari					ninata Bo		-unavail-
em 27 is ma		19a. Informant's Name/Relation <b>Keisha Jacks</b>	nship (Type, Print) on/Wife		g Address (Street and 1 Landover				
Importent: If item any injury or othe Or ite.			3 ∏Removal from State	20b. Place of Dispo cemetery, cren	sition (Name of natory or other place)		ate 200	. Location - City or	
rtent njury	-	`4 □Donation 5 □Other (			ion Cemete			linton,Ma	aryland
any in		21. Six entre of Full rail Service	e Licensee		. Name and Address	••	B. Jenki	ns Funera	al Home
	+	23a. Part1. Enter the disease, of shoot or heart failure. I	or complications that caused th	e death. Do not ente	474 Landov	ver Road	Landover	, Maryla	Approximate
sician edical miner		Immediate Cause (Final disease or condition resulting in death)	storny one cause on each line.	Failure					Interval Between Onset and Death
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Cisasse or injury that initiated events	b. Hyper  Due to (or as a c	tension					
the burial-transit	icai Exa	resulting in death) Last	Due to (or as a o	consequence of):					
as s	ฮ์ 🗕	F FEMALE:							
by the attending phase to tached for use as the		23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1□Live birth 2 [ 4□Pregnant at tim 9□ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	ivery Day Year
be d	מׁ מֹ	art II. Other significant conditi	ions contributing to death but r	not resulting in the un	derlying cause given i	in Part I.	23e. Did tobaco		the cause of death?
has ye 2	naldillo						24a. Was an autopsy performed	prior to death?	itopsy findings availab completion of cause o
ector, pag	D 2	25. Was case referred to medica examiner?	al		26	6. Place of Death	1 Yes 2X	NO TOTES	2 <mark>▼</mark> No
this call dire	2	1 ☐ Yes 2 🔀 No	Hospital: 1 Inpatient	2 ER/Outpatient	Other		e 5 Residence	6 ☐ Other (Spe	cify)
tor: After the funera	2	E C. 1. 100 100 111	igation	28b. Time of Injury	28c. Injury at Work?  M 1 Yes	2 □ No	8d. Describe how in	ijury occurred	
by 5		3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ		- At home, farm, stre Specify)	et, factory, office	2	Bf. Location (Street City or Town, St	and Number or Ru ate)	ral Route Number,
To the Funeral Discompletely filled in Medical Cert		one)	ng Physicien: To the best of m Examiner: On the basis of ex and manner stated	amination and/or invi	occurred at the time, ostigation, in my opinion	date and place, ar on, death occurre	nd due to the cause d at the time, date a	(s) and manner as and place, and due	stated. to the cause(s)
comple		9b. Signature and title of certifie		)	29c. License nu	umber	29d. I	Date signed (Month	n, Day, Year)
)	-	0. Name and address of person	who completed course of different	(ltom 22c) 77 = 5	D-1925	50	Ma	rch 11,	2005
	1 3	o. Hame and address of person	with completed cause of deal	я (пет 23а) (Туре, Р	rint)				
/		Jae/Chung M.D.	9470 Annapol i	s Road #	306 Lanhan	n. Marul	and 20704		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 0105 A 2005 Berry March /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Montgomery Hospice - Casey House
5. Social Security Number | 6. Sex | 7. Age (In yrs. last bir ASEY HOUSE
7. Age (In yrs. last birthday)
Yrs.

Yrs.

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RI Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Montgomery 9. Birthplace Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1□M 25 F Director 124-18-9749 June 4, 1927 New York Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h Count 28e-f show r than "netural", or items 23s or 28s-f shov the Medical Examinational be notified at 1 ☐ Yes 2 ☑ No Directo Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3629 Glen Eagles Drive 20906 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. withIn 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify δ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) I Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 12 Bookkeeper Accounting Ith and Mental Hygis 27 Is marked other r treumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be þe Isaac Mayo Stella Azuz P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If Item 27 Is Silver Spring, Maryland 20906 Robert A. Berry Husband 3629 Glen Eagles Drive other 1 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State injury of Parklawn Memorial artment ortent: If ⁴ 4 □Donation 5 □ Other (Specify) Mar. 14, 2005 Rockville, Maryland Park 22. Name and Address of Facility
Francis J. Collins Funeral Home, Inc. 21. Signature of Funeral Service Licensee any in 5 500 University Blvd., W., Silver Spring, MD 20901 23a. Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Coecal Volvulus /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine certificate be executed nding physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) signed by the a o. 9 Unknown σ, The law requires that 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown End Stage Alzheimer's Dementia been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Diabetes Mellitus has e 2 autopsy performed? certificate has rector, page 2 1 ☐ Yes 1 ☐ Yes 2X No Essential Hypertension Vital 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other  $4 \square$  Nursing Home  $5 \square$  Residence  $6 \times O$ ther (Specify) Hospice Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 X No Certification: To ä o After thi 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c Injury at Work? 5 Pending Division 1 XNatural M 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after o To the Funerel Directory completely filled in by 4 Homicide 50 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certification 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6001 Muncaster Mill Road Rockville, Maryland Charles Harrison, M.D. 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 1 4 2005 MAR Registrar

CPM 05-01452 Georgia Bedell

~ 6 <del>-</del>			For State Registrar	State of M	laryland / Depa <i>Cei</i>	artment of Heal rtificate of Dea		ntal Hygien Reg. N	2005	10454
	Physici	an	Decedent's Name (First, Middle, Last)     GEORGIA BEDE	LL				Date of Death Month	ay Year	3. Time of Death
	/Medic Examin	al	4a. Fecility Name (If not institution, give s	treet and number	)	4b. City, Town, or Loca			25, 2005 c. County of Death	07:56 A <sup>M</sup>
	LAdimii		Laurel Regional Ho	ospital		Laurel		I	rince Geo	orge's
	Funeral Director		5. Social Security Number 6. Sex 217-71-2016	7. A M 2 <b>∏</b> F	ge (In yrs. last birthday) Yrs.		Jnder 24 Hrs. 8 ours Min.	Date of Birth (Month, Day, Year 12-15-04		lace (State or Foreign try) h., D.C.
	D		Usual Residence of Decedent					12-13-0		
	anylar show	'n	10a. State 10b. County		10c. City, Town or Lo				1	0d. Inside City Limits 1 ♣Yes 2 No
	28a-f	Director	Md. Montgo	nery		Burtonsv	ille	10a, C	itizen of What Coun	
	3a or		3902 Greencast	le Ridge	Drive #404	2	.0866		United S	•
	ems 2	Funeral		12. Was Deceden Armed Forces		Was Decedent of Hispan f Yes, specify Cuban, Me		fy Yes or No- can, etc.)	14. Race - Americ Black, White,	an Indian,
36	72 hours after death with the Maryland natural', or Items 23a or 28a-f show lical Examinar must be notified at	by Fu	12© Never Married 2  Married 3  Widowed 4  Divorced	1 ☐ Yes 23€ If Yes, Give Year or Dates:	No		ecify:		Specific	
8	2 hour atural cal Ex	ted t	15. Decedent's Educ	cation	16a, Dece	dent's Usual Occupation		16b.	B1a	
21215-0036	.⊆ 2	Completed	(Specify only highest grade	College (1-4or	lite	kind of work done during DO NOT use retired)	g most of working			
d 2	filed with Hygiene. Ither than	e Co	17. Father's Name (First, Middle, Last)			18.	Mother's Name (	First, Middle, Maide	n Sumame)	
Maryland		To B	Thomas Bedell				Rosa	lind Eker	nam	
lary	and and sm	1	19a. Informant's Name/Relationship (Ty)	•		ng Address (Street and N				20000
	item 27	1	Thomas Bedell / Fa	ather		Greencastle	Ridge I		Burtonsv: ocation - City or To	
nor	0 = 5		1 ☑ Burial 2 ☐ Cremation 3 ☐ R  '4 ☐ Dojlatjon 5 ☐ Other (Specify)	emoval from State		sition (Name of natory or other place)  Memorial P			Laurel,	
Baltimore,	permit. Pag Department Important: any injury o		21. Signature of Funeral Service Ucen	9	1 1/2 22	2. Name and Address of			ary, Inc.	
	0.D.E. 6 0		23a Part Enter the disease of compli	cations that cause	the death. Do not ent	425 Marylan	d Ave.,	NE Wash	, DC 200	002 Approximate
	a Pnysician		shock, or heart failure. List only or Immediate Cause (Final		eninaiti			oopatory arroot,	Į(	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)		s a consequence of):					
	Examiner	L	Sequentially list conditions,	Due to for a	s a consequence of):					
	uted I Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause juisease or injury	Due to (or a	s a consequence or;					
o,	icate be executed physician and s the burial-transit	Еха	that initiated events cresulting in death) Last	Due to (or a	s a consequence of):					
68760,	cate be	edical		l						
9 xo	seath certific attending p	√Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcom					23d. Date of delive	ry
.O. Bo	at the death by the atte tached for	Physiclan/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown			Ectopic pregnancy Other (specify)			Month	Day Year
٩	es that thigned by	by Ph	Part II. Other significant conditions cor	tributing to death	but not resulting in the u	nderlying cause given in	Part I.	23e. Did tobacco	use contribute to th	e cause of death?
ecords,	w requires been sign should be							1 ☐ Yes 2	Prob	abty 4 □Unknown
$\alpha$	has has	Completed						24a. Was an autopsy performed?	prior to con death?	osy findings available inpletion of cause of
Vital		O	25. Was case referred to medical			26.	Place of Death (	1 Yes 2 N Check only one)	o 1 ⊿\Yes	2 No
of V	Physician: this certific	To B	I A 195 Z INO	ospital: 1   Inpat			10/19/0		6 □Other (Specify	)
	Jing After fune	atlon:	27. Manner of Death  1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of In (Month, D	jury 28b. Time o lay Year) Injury	28c. Injury at Work?  M 1 Yes		d. Describe how inj	ury occurred	
Division	I or Attending after death. Director: Afte I in by the fune	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inbuilding, 6	njury - At home, farm, str etc. (Specify)	eet, factory, office	28	f. Location (Street a City or Town, Sta	nd Number or Rura e)	Route Number,
	To the Hospital within 24 hours of To the Funeral I completely filled	Medical C			t of my knowledge, deat of examination and/or in stated.					
	To the vithin To the Compl	Me	29b. Signature and title of certifier			29c. License nun	mber	29d. D	ate signed (Month, I	Day, Year)
			Levral H	allan	ud	OCME		Feb	ruary 26,	2005
K	2		30. Name and address of person who co	mpleted cause of	death (Item 23a) (Type,	Print) 111 Penn	Street	Baltimo	re, Maryl	and 21201
	Sta Regist		31. Date filed (Month, Day, Year)  MAR 1 4 200	3 Regis	trar's Signature	will !				

			1 - For 3-14-05 State Registrar Amend #27-1	State of Per Phys.R	Marylan 3C cr		artment					giene Reg. No.	005	10455
3	147. January 1		1. Decedent's Name (First, Middle	, Last)		-				:	2. Date of De	ath Day	Year	3. Time of Death
	Physici /Medic		PATRICIA	B	USH						FEBRUA		5, 2005	8:05 <sup>a м</sup>
7	Examin		4a. Facility Name (If not institution	-			4b. City,	Town, or	Location of	of Death		4c.	County of Dea	th
			PRINCE GEORGE'S				16 1 1		VERLY				RINCE G	
	Funeral		5. Social Security Number 579-72-3644	6. Sex 7.	. Age (In yrs.	50 Yrs.	If Under Months	Days	If Under	Min.	8. Date of Birl (Month, Da	h y Year)	9. Bin	thplace (State or Foreign buntry)
	Director		Usual Residence of Decedent	i		30				J	une 15	, 15	154 Wasi	hington, D.C.
	ylanc how		10a. State 10b. County		10c. Cit	y, Town or Lo	cation	ø,						10d. Inside City Limits
	e Maria	ctor	D.C			WA	SHING	TON						1 ☑ Yes 2 ☐ No
	or 28	Dire	10e. Street and Number				10f. Zip	Code				10g. Citi	zen of What Co	ountry?
	ath w	rai	315 61 St. N.E.			- 1			0019				nited S	
	ter de Items	Funeral Director	11. Marital Status  1 □ Never Married 2 □ Marri	12. Was Deced Armed Forced 1 ☐ Yes 2	es?	.S. 13. \	Vas Deced f Yes, spec	ent of His ify Cubar	spanic Orig n, Mexican	gin? (Spec n, Puerto R	ify Yes or No ican, etc.)	-	<ol> <li>Race - Ame Black, Whit</li> </ol>	
36	urs aff	by F	3 ☐ Widowed 4 € Divorced	If Yes, Give Year or Date			1□Yes 2	2₩ No	Specify:				Specify:	lack
21215-0036	72 hours after death with the Maryland natural', or Items 23a or 28a-f show afted Examitter coulded at	ted	15. Decedent	's Education		16a. Deced	lent's Usua	l Occupa	ition			16b. Ki	nd of Business/	
21	within 7 ene. than "r	nple	(Specify only highes Elementary/Secondary (0-12)	College (1-4	4or 5+)	life. L	kind of wor OO NOT us	e retired)	) )	t ot working	9			
2	filed wi Hygien other th	Completed	12th				Te	1eph	one (				Marketi	ng
nd	be fill stal H d oth	Be	17. Father's Name (First, Middle, I								(First, Middle,		Sumame)	
Z	2 should be filed v and Mental Hygie 1s marked other t raumatic event, III	은	Luther Willi			405 14-18-		(0)			Reedy		- A	
Maryland	d 2 sh th and 7 Is n traun		19a. Informant's Name/Relationsh Terri Briscoe								D.C. 2		Town, State, 2	(ip Code)
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, It's Modical Examination that be rediffied at once.		20a. Method of Disposition	,	20b. P	lace of Dispo	sition (Nam	e of	1	Da			cation - City or	Town, State
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Ħ	artmoortar		21. Sign tile Funeral Servic		0 1		. Name and				05			Mortuary
ä	Depariming Department on the once		> Marve 2	thuson	Mill	My 14	25 Ma	ry1a	nd Av	ve.,	N.E. W			D.C. 20002
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cau	used the death	n. Denot ente	er the mode	of dying	g, such as	cardiac or	respiratory ar	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Chr	ch'line.	201746	m cfi	ىك	and	mon	b pla	use	prop	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or	r as a consequ		0.1							
	LAdillillei	<u>_</u>	Sequentially list conditions, if any, leading to immediate	b. Director(e)	r as a consequ	apr			(5)					
	ted nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	C .~	-9 e St	tule	Low	X	7	wil	عس			
^	axecu and al-tra	xar	that initiated events resulting in death) Last	Due to (or	r as a consequ	uence of):		4.						
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9	tificat og phy as th	Physician/Medical	15.551.44.5											
Вох	eath certific attending pl	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	ome of pregna th 2 DFetal		lEctopic pre	anancy				2	3d. Date of deli	
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Division of Vital Records,	l or Atte after de Directo I in by th	Certification:	3 Suicide SMCould of determine		f Injury - At ho g, etc. <i>(Specif</i> )		et, factory,	office		28	If. Location (S City or Tow	Street and m, State)	Number or Ru	ıral Route Number,
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	To the Hospital or Atlending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Med	29h Signature and title of dartifier	1111	. stated.		29c.	License	number			29d. Date	signed (Month	ı, Day, Year)
)	⊢s⊢ō		mosi	W. T.	IMD		D	005	998	31			5105	
2	2		30. Name and address of person v	who completed cause	of death (Item	1 23a) (Type, I	Print)							
1	(2)		Mukemil	abdello	, we	· ·	3001	thist	MAL	DRIV	E	CHE	ERLY,	MD 20785
	Sta		31. Date filed (Month, Day, Year)	P. Rec	gistrar's Signa	ture	-							
	Registr	ar	MAR 1 4 2	005	w B	Ana	W							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1 Decedent's Name (First, Middle, Last) Month Day **Physician** March 14, 2005 4:54 A Robert Douglas Bonney /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery 17720 Pond Road Ashton If Under 1 Year Months Days If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Min Hours 1X M 2□ F 48 Nov 10, 1956 Ohio Director 288-54-7785 Usual Residence of Deceden e filed within 72 hours after death with the Maryland at Hygiene. other than "natural", or Itema 23a or 28a-1 show 10c. City. Town or Location 10b. County 10d. Inside City Limits 10a State ral", or Itema 23a or 28a-f show Evanings must be notified at 1 ☐ Yes 2 X No Director Ashton Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20861 USA 17720 Pond Road Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify: Specify: Caucasian 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) the Medical 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) Electrical Engineer Optics 17. Father's Name (First, Middle, Last) 18. Mother's Name /First, Middle, Maiden Sumame. permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Ia marked oth any liury or other traumatic event sones. Be Ellen Jeane Wentworth Douglas McDowell Bonney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17720 Pond Road Ashton, Maryland 20861 Mary L. Heimer/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Marchate 15. 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Arundel Crematory 2005 Odenton, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Going Home Cremation Service P.O. Box 784 21. Signature of Funeral Service Licens Dever MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 天 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

3 YEARS METASTATIC PROSIATE CANCEN Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown n signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has b rector, page 2 s autopsy 20X No 1 Yes Physician: director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 X No Certification: To this After this funeral d 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Hospital or Attanding 1 Natural Injury 5 Pending 1 TYes 2 No investigation death. 2 Accident the Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifiei Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MO 2005 14/8 D52768 Enewsey e and address of person who completed cause of death (Item 23a) (Type, Print) MARLO A. EISENREAGEN MD JOHNS HOPKINS HOSPITAL, 1650 ORLEANS ST 1MSI , BALTIMORE, MD 21231-1000 Year)

Registrar DHMH 17 Rev 1/2001

State

32. Egistrar's Signature

2005

State of Maryland / Department of Health and Mental Hygiene 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death Month 133 M **Physician** March 2005 Deborah A. Cardinale 11 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** 8532 Harvest View Court Ellicott City Howard If Under 1 Year | If Under 24 Hrs. Birthplece (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 228 02 8417 45 11, 1959 Virginia Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f ehow the Medical Examiner must be notified at 1 Yes 3 No Director MD Howard Ellicott City 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò 8532 Harvest View Court 21043 United States Items 23a Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status o filed within 72 hours after de il Hygiene. other then "natural", or Item 1 ☐Yes 2 XNo 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates: þ 3 ☐ Widowed 4 ☐ Divorced White Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Accountant ith and Mental Hygier 27 Is marked other the r traumatic event, the permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked other any injury or other traumation. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Anthony Cardinale Patricia M. Wilson ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8532 Harvest View Court Elliott City, MD 21043 Benjamin R. Baker, Jr./Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory \* 4 ☐ Donation 5 ☐ Other (Specify) 3-14-2005 Catonsville, MD 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee 7MO1044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that saused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat Asphyxia **Physician** min D. resulting in death) /Medical Due to (or as a consequence of): Examiner YEAVS oression Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner as the burial-transit or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician. Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths? Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ٥ atrogenic Narcotic Addiction 2 No 1 Yes 3 Probably 4 □Unknown Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an cate has page 2 s autopsy 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Yes 2 No this 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Pay Year) After 1 Natural 5 Pending selfinflicted hanging 17:33 1 ☐ Yes 2 ☐ Mo 2 Aceldent investigation mar 11/05 the f Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide 8532 Harvest View home within 24 hours a To the Funeral I To the Hospital 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Addical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number March 12,2005 WE U 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4565 ATTRYCE A. TOKE, NW 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar	State of Marylan		irtment of H			iene	05 1045
Physicia		1. Decedent's Name (First, Middle, Last	m	Cur	tin		2. Date of Deat Month	h Day	Year // S4 A
/Medic Examin	_	4a. Facility Name (If not institution, give	street and number)	tel		r Location of Death	1777	4c. County of	
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Maryland	tor	10a. State 10b. County  MD Howard		ty, Town or Lo					10d. Inside City Limi 1 ☐ Yes 2 🔀
h with the 23a or 28a at be nuti	Funeral Director	10e. Street and Number 10712 Bridlerein		<b>31010</b>	10f. Zip Code 21044		10	og. Citizen of Wh United	•
s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If Health and Mental Hygiene item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, tra Medical Examinat must be notified at	by Funer	11. Maritat Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: WWII		Vas Decedent of H i Yes, specify Cuba □ Yes 2☑ No	lispanic Origin? (Sa an, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)		- American Indian, White, etc. White
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and 2 should be fill saith and Mental H; n 27 is marked oth	၉	19a. Informant's Name/Relationship (T) Patricia A. Neidic				and Number or Rui	ral Route Number,		
permit. Pages 1 and 2 Department of Health mportant: if item 27 i any injury or other tru		20a. Method of Disposition  1	20b. F Removal from State	Place of Dispos cemetery, cren	sition (Name of natory or other place eaven Cer	:ө)	Date 2		city or Town, State
permit. Pages Department of Important: If is any injury or once.		21. Signature of Funeral Service Licens	MO10	)44 22 41	Name and Address	ss of Facility Har olumbia P	ry H. Wi Pike Elli	tzke's l .cott Ci	Family FH Ind ty, MD 21043
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ath certific titending p	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	al death 3	Ectopic pregnancy Other (specify)	,		23d. Date Monti	
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he Hosp in 24 hou he Fune pletely fil	Medical		rsician: To the best of my kno iner: On the basis of examina and manner stated.	ation and/or inv	estigation, in my o	pinion, death occur	red at the time, da	ate and place, an	nd due to the cause(s)
To t with To t	2	29b. Signature and title of a riffier	Alexander Co	(ino	29c. Licens	6/309	7	Pd. Date signed (	(Month, Day, Year) 10, 7,005 MD 21044
3		30. Name and address of person who of Ricxunder Churche	ompleted cause of death (MAr	1085 (Type,	Print) - LHGPE	turnt for	-kary C	olumbia,	MD 21044
Sta Registr	-	31. Date filed (Month, Day, Year)	32. Registrar's Signa	21010					

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	Physicia	an	Decedent's Name (First, Middle, Last)				2. Date of Deat Month	h Day Year	3. Time of Death
	/Medic		GEORGE ROBERT	DORANG			MARCH	22 200	5   12:00p <sup>M</sup>
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-	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday			8. Date of Birth	Kent	irthplace (State or Foreign
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21215-0036	tural'	ed by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Educate	Year or Dates: -1945	edent's Usual Occup	ation		16b. Kind of Busines	
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Maryland	nd 2 sh alth and 27 Is n ir treun		19a. Informant's Name/Relationship (Type, Lucille T. Dora:			and Number or Rural t Park R			
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Вох	death s atter d for u	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of death 5	□Ectopic pregnancy □ Other <i>(specify)</i> _	<u>'</u>		Month	Day Year
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	es that the death cer igned by the attendin be detached for use	by	Part II. Other significant conditions contri		A .		1 _		to the cause of death?
ord	w requir been si should	sted	ASCAU, A	y pertension,	Custesta	(70)	1 \ Ye	s 2 No 3 □ I	Probably 4 ⊡Unknown
3ec	e law has b	Completed					24a. Was ar autops perforn	y prior to	autopsy findings available ocompletion of cause of
Vital Records,	n: Th ficate nr, pag		OF Was seen intered to modical				1 Yes 2	1 Ye	
5	/sicle s certi	o Be	25. Was case referred to medical examiner?	pital: 1  Inpatient 2 ER/Outpatie	ont 3 DOA Oth	26. Place of Death er: 4 ☐ Nursing Hom		e) ince 6 □Other (Sp	ecify)
10	ig Phy ter thi neral (	n: T		28a. Date of Injury 28b. Time ( (Month, Day Year) Injury	The state of the s	y at 28	-	w injury occurred	outy
Sior	endin sath. or: Aft he fur	atio	1 SNatural 5 Pending 2 Accident investigation	(,, 2-) 14-,,		Yes 2 □ No			
Division of	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	<ol> <li>Place of Injury - At home, farm, st building, etc. (Specify)</li> </ol>	treet, factory, office	2	8f. Location (Sti City or Town	reet and Number or I i, State)	Rural Route Number,
	ours a		29a. Certifier Certifying Physic	ian: To the best of my knowledge, dea	th occurrent at the tin	ne date and place as	nd due to the ca	ausa/s) and manner	as stated
	To the Hospitel or Attending Physicien: The lawithin 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	edical	(Check only 2 Medical Examiner one)	r: On the basis of examination and/or is and manner stated.	nvestigation, in my o	pinion, death occurred	d at the time, da	ate and place, and di	ue to the cause(s)
	To the To the Comp	Me	29b. Signature and the of sertifier		29c. Licens		29	9d. Date signed (Mor	
)			e A o	~ \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	(A)	51735		3)23)	05.
	axl		30. None and address of person who comp						
	Sta	to	Frederick Delbe	22 Rosetrar's Signature		H <b>ill</b> Rd.	Chest	ertown,	MD. 21620
	Registi		MAR 2 8 20		Charles !				

			1 - Stete Registrar			d / Depa		of H	lealth a	and M	lental Hy		0.05	10460
		0	Decedent's Name (First, Middle	e, Last)							2. Date of De	ath		3. Time of Death
	Physici		MILDRED	LOUISE	ELY						Month MARCI	Day H 10 2	Year 2005	12:00 P <sup>M</sup>
j	/Medic Examin		4a. Facility Name (If not institution				4b. City,	Town, or	Location of	of Death	11111101		unty of Death	
	LXaiiiii	C.		Memorial Ho			Fr	ede	rick			Fi	rederi	ck
	Funeral	-	5. Social Security Number		Age (In yrs. I		If Under		If Under		8. Date of Bir	th		place (State or Foreign ntry)
	Director		220-28-8742	1 □ M 2√2 F	86	Yrs.	Months	Days	Hours	Min.	June 1	2,1918	Mar	vland
	<b>D</b> .		Usual Residence of Decedent											
	inylar show	_	Maryland Fred	erick	10c. City	, Town or Lo								10d. Inside City Limits
	e Ma	cto	naryiand Fred	erick		DLUII	swick							1 <b>Ø</b> Yes 2 □ No
	or 24	Oire	10e. Street and Number				10f. Zip					10g. Citizen	of What Cou	ntry?
	23a	ra	9 Ninth Avenu					1716				Unite		
	r dez	ıne	11. Marital Status	12. Was Decede Armed Force	es?	S. 13.	Was Deced If Yes, spec	ent of Hi ify Cuba	ispanic Ori n, Mexicar	igin? (Sp n, Puerto	ecify Yes or No Rican, etc.)	o- 14. i	Race - Ameri Black, White,	
36	s afte	y F	1 Never Married 2 Marr	If Yes Give	<i>'</i>		1 ☐ Yes 2	No.	Specify:			Spe	ecify:	
Ö	72 hours after death with the Maryland natural; or Items 23a or 28a-f show dital Examinat must be indiffed at	Completed by Funeral Director	3   Widowed 4 □ Divorced	Year or Date	3S:	16a D-44	de elle I le .e	1.000	-41			10h Kinda		ite
15	n 72	ete	(Specify only highe	st grade completed)		(Give	dent's Usua kind of wor DO NOT us	k done d e retired	ation du <i>ring</i> mos	it of work	ing	160, King C	of Business/Ir	ndustry
12	within ene. than "	щ	Elementary/Secondary (0-12)	College (1-4	or 5+)		me mal		,			OLI	n home	
2	filed with Hygiene other thai		17. Father's Name (First, Middle,	Last)		110	me mar	CEL	18. Mothe	er's Nam	e (First, Middle			
an	d be antal ced o	To Be	Vernon		Wiles			ľ	Re	rtie		1	Fox	
2	and Mental smarked c	Ĕ	19a. Informant's Name/Relations	ship (Type, Print)	WILCS	19b. Maili	na Address	(Street a			al Route Numb			o Code)
Maryland 21215-0036			Charles C. Virt			1	•				ick , M			
ē	t and Health tem 27 other tr		20a. Method of Disposition		20b. Pl	lace of Dispo	osition (Nam	e of	1		Date 1		on - City or T	own, State
Baltimore,	Pages nent of int. If it		1 ☑ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (S	3 Removal from St	ate	emetery, cre Lth U.	-			02/12	/2005	T7 1	1. M	. 2024
Ė	- 문문을	1	21. Signature of Funeral Service		Fal		2. Name and							aryland es, P.A.
Ba	permi Depa Impo any ir	0.70	Packnond	190101	1-1						.ke/ Fre			21702
			23a. Part1 Enter the disease, or	r complications that cau	sed the death								K, 11D	Approximate
			shoot or heart failure. List Immediate Cause (Final	only one cause on each	th line.	1								Interval Between Onset and Death
9	Physician /Medical		disease or condition resulting in death)	a. V19h	as a consequ	-	nmin.	-						
	Examiner			(10	as a consequ	An		2.1						
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or	as a consequ	ience of):	VI A	nijvi	10					
	be executed sician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	<										
,	exec n and ial-tra	Еха	resulting in death) Last	Due to (or	as a consequ	ience of):								
760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	cal		d.										
89	ificat g phy as th													
Вох	ndin use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco			75.00000					23d.	Date of deliv	ery
m	death a atte d for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnar	h 2 ∏Fetal nt at time of de		☐Ectopic pre☐Other (spe						Month	Day Year
P.0	oy the	hys	9 □ Unknown	9□ Unknow	n									
	w requires that the death certifica been signed by the attending ph should be detached for use as th		Part II. Other significant conditi	ons contributing to dea	th but not resu	ilting in the u	inderlying ca	use give	en in Part I		23e. Did 1	tobacco use o	contribute to t	the cause of death?
ğ	w require been sig should b	edt	Mypumater	1 or thrit	Li , 1	hypers	Husin	٠,			1 🗆	Yes 2□N	o 3 ☐ Proi	bably 4 Dunknown
Records,	s bee	Completed by	USTPONENSIN	austries	shum	1 4	Place	Asi	Call		24a. Was			opsy findings available
Re	The lav te has age 2	m <sub>o</sub>	-10/200211	9.50,20.3	1		100	0 1 1	1-10.			psy ormed? 2 X No	death?	mpletion of cause of
ta		BeC	25. Was case referred to medica	al .					26. Place	of Deat	1 ☐ Yes		1 1 1 1 1 1 1 1 1 1	20110
√ <u>&gt;</u>	ysici is cer direc	To B	examiner? 1 Tes 2 Ne	Hospital:	atient 2 1	ER/Outpatie	nt 3 DO	A Othe			me 5□Resi		Other (Specia	(v)
ō	ding Physician: The In. After this certificate ha		27. Manner of Death	28a. Date of		28b. Time of		Bc. Injury	/ at		28d. Describe			,,
, <u>o</u>	nding F ath. r: After e funera	atio	1 → Matural 5 ☐ Pendir 2 ☐ Accident investi	'3	Day roury	Highly	М		Yes 2	No				
Division	I or Attendi after death. Director: A I in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 200. Place U	f Injury - At ho	me, farm, st	reet, factory	office		-		Street and No	umber or Run	al Route Number,
O	tal or s afte al Dii	Cert		January	, oto. (opour)	,					0, 0	, 0.0.0)		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier 1 Certifyii	ng Physician: To the b Examiner: On the bas	est of my know	wledge, deat	h occurred a	at the tim	ne, date an	nd place,	and due to the	cause(s) and	manner as s	stated.
	in 24 he F. he F. plete	Medical	one)	and manne	r stated.	JOH ANG/OF IF				au occur	ou at 1118 (111)8,			
	To the To the comple	Σ	29b. Signature and title of certifie	1/1/1/	and	,	29c.	License	number				gned (Month,	
					1000)			03	7/7	8		8-	03,11,	05
	V		30. Name and address of person	who completed cause	of death (Item	23a) (Type,	Print)							
			Christopher J				enth S	t./	Fred	eric	k, Mary	land	21701	
	Sta		31. Date filed (Month Payr Year)		istrar's Signal	ture								
-	Registi	ar				State of	730E	B						

			1 - For State of Maryland / State of Maryland /	-	artment of He		nd Me		iene	5	101.61
ı	Physici		Decedent's Name (First, Middle, Last)  Mary Ann Foohey			******	2	. Date of Deat Month	h Day	Yeer	3. Time of Death
l	/Medic Examin		4a. Facility Name (If not institution, give street and number)  Montgomery General Hospital		4b. City, Town, or O1	Location of ney	Death	Murch	4c. County of	Death tgom	
	Funeral Director		5. Social Security Number 6. Sex 1. Age (In yrs. last to 1. 1. Age (In yrs. last to 1. Age (In yrs. l	oirthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	4 Hrs. 8 Min.	Date of Birth (Month, Day, July 13	Year) , 1936	9. Birthpl Coun Del	lace (State or Foreign try) aware
	Maryland -f show lied at	tor	Usual Residence of Decedent           10a. State         10b. County         10c. City, To           Maryland         Montgomery         Sa		cation Spring					10	0d. Inside City Limits 1 ☐ Yes 2 🖾 No
	3a or 288	Il Director	10e. Street and Number 1637 Hickory Knoll Road, #6		10f. Zip Code 208	60		1	0g. Citizen of Wh	nat Coun	try?
920	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23s or 28s-f show raumatic event, the Medical Exstringt must be notified at	by Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	- 1	Was Decedent of His f Yes, specify Cubar I □ Yes 2 No	spanic Origin, Mexican,	in? (Speci Puerto Ri	fy Yes or No- can, etc.)	14. Race Black, Specify:	White, e	etc.
Maryland 21215-0036	within 72 hou lene. 'than "natura' 're Madical E	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+) 5+	(Give life. L	lent's Usual Occupa kind of work done d DO NOT use retired) rarian	urina most i	of working		16b. Kind of Busi		·
and 2	ld be filed ental Hygi ked other ic event, I	ø	17. Father's Name (First, Middle, Last) William L. Foohey						Maiden Sumame; e Pflag:	)	01 40 001
Mary	nd 2 shou aith and M 27 is mar	-	19a. Informant's Name/Relationship (Type, Print)  Sean P. Foohey/Brother		g Address (Street a						,
altimore,	permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 Is marked any Injury or other traumatic evonce.		1 Burial 2 ☐ Cremation 3 ☐ Removat from State cemel	tery, cren	sition (Name of natory or other place aven Cemete:		March 200		20c. Location - C		wn, State g, Maryland
Balti	permit. Departm Importa any Inju		21. Signature of Funeral Service Licens		Name and Address ancis 00 Univer		ins F	uneral	Home In	c.	, MD 20901
8760,	/Medical Examiner on physician and the prinal-transit the burial-transit	dical Examiner	shock, or head failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause; Lisease or in the Cause of Cause. Enter Underlying Cause of Cause. Enter Underlying Cause of Cause. Enter Underlying Cause of Cause. Enter Underlying Cause of	e of):	Crest (	anve					Interval Between Onset and Death
O. Box 68	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burral-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death		Ectopic pregnancy Other (specify)				23d. Date of Month		ry Day Year
rds, P.	w requires that i been signed by should be deta	ρ	Part II. Other significant conditions contributing to death but not resulting	in the ur	nderlying cause give	n in Part I.		23e. Did tob	11	ute to the	e cause of death? ably 4 <u>Unknown</u>
al Records,		Completed	_ Chronz obstructive Pulmona	y	Directe			24a. Was ar autops perform 1 Yes 2	v prid	or to com ath?	psy findings available appletion of cause of
Division of Vital	To the Hospital or Attanding Physician: Th within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, pag	To Be	25. Was case referred to medical examiner?  1	Outpatien Time of Injury	t 3 DOA Other	. 4 □ Nurs	sing Home		a) nce 6 ⊡Other w injury occurred		)
DIVIS	tal or Attsndi s after death. al Director: A ad in by the fu	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, stre	eet, factory, office		281	Location (Str City or Town	reet and Number , State)	or Rural	Route Number,
	To the Hospital or Attsndi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical (	29a. Certifier (Check only one)  Certifying Physicien: To the best of my knowled 2 ☐ Medical Exeminer: On the basis of examination and manner stated.	ge, death and/or inv	occurred at the time restigation, in my opi	e, date and nion, death	place, and occurred	d due to the ca at the time, da	use(s) and mann ite and place, and	er as sta d due to	ited. the cause(s)
	To To com	2	29b. Signature and title of certifier		29c. License		ç		March		Day, Year)
	10		30. Name and address of person who completed cause of death (Item 23a	(Type, I	Print) Da, i	20	unch	mo 208:		10	,
	Sta Registr		31. Date filed (Month, Day, Year) MAR 1 4 2005	do	who ?						

State of Maryland / Department of Health and Mental Hygiene State Registrar AMEND ITEM #3 PER PHY C842 49 15 Gate of Death Reg. No. Time of Death 4:03pm 1. Decedent's Name (First, Middle, Last, 2. Date of Death Month Day **Physician** Charles E. Ford March 10, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital Olney Montgomery 8. Date of Birth (Month, Day, Year) July 30, 1 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1⊠M 2□F 578-52-8162 Yrs. 64 1940 Washington, Director Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral, or itema 23a or 28a-f shov Examiner must be notified at 28a-f shov 1 Yes 2 No Maryland Directo Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2617 Bainbridge Lane 20906 USA filed withIn 72 hours after death Hygiene. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 "natural', or 1 ☐ Yes 2 No ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Artist/Graphic Designer Art & Graphic Design mil. Pages 1 and 2 should be filed v partment of Health and Mental Hygie portant: If Itam 27 is marked other t y injury or other traumatic event, ID other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Brooks Ford Jasmine Elizabeth Lester 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marjorie Jo Ford/ Wife 2617 Bainbridge Lane, Silver Spring, Md 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State March 16 pernit. Page Department of Important: If any injury or Gate of Heaven Cemetery ` 4 ☐ Donation 5 ☐ Other (Specify) 2005 Silver Spring, Maryland 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Myocardial Infarction /Medical resulting in death) Due to (or as a consequence of): Examiner Chronic Obstructive Pulmonary Disease - Oxygen Requiring Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Dualto (or as a consequence of): Phyaician: The law requires that the death certificate be executed burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physiclan by Physician/Medical as the IF FEMALE esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy jo in the past 12 months? Month Year Dav 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the detached 9 Unknown 9 Unknown ģ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 99 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed? certificate 1 Tyes 2 □ No director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 XNo 3□ DOA this funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t Certification: or Attending 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide Hospital 24 hours a Medical 29a, Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 2 one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D18813 March 11, 2005 221 10 30. Name and address of person who completed cause of death (Item 23a) (Typa Ira Tauber, M.D. 10301 Georgia Avenue, #304, Silver Spring, MD 20902 31. Date filed (Month Pay, registrar's Signature State Registrar

			1 - For State (	of Maryland / Depa	artment			and M		giene Reg. No.	05	0463
П	Physici	an	Decedent's Name (First, Middle, Last)						2. Date of De Month	ath Day	Year	3. Time of Death
	/Media		Ronald Michael Forna						03	08	2005	10:40 P <sup>M</sup>
	Examir	er	4a. Facility Name (If not institution, give street and not 1200 Ashton Rd	imber)	Asht		Location o	of Death			County of Death	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under	1 Year	If Under 2		8. Date of Bir	th	ntgomer 9. Birth	place (State or Foreign
L	Director		114-24-2513 <sup>1⊠M 2□F</sup>	72 Yrs.	Months	Days	Hours	Min.	(Month, Da 02/25/		Cou	ntry) NY
	pur *		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	ocation							
	Aaryla f sho	or	MD Montgomery	Ashton	Joution							10d. Inside City Limits 1 XYes 2 No
	28a-	Director	10e. Street and Number		10f. Zip	Code				10g. Citiz	en of What Cou	ntry?
	h with	al D	1200 Ashton Rd		208	861				Uni	ted Sta	tes
	ems (	Funeral	11. Marital Status 12. Was De	cedent Ever in U.S. 13.	Was Deced	ent of Hi	spanic Orig	gin? (Spe	cify Yes or No	)- 1·	4. Race - Ameri Black, White,	
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes	2 No	1 ☐ Yes 2	_	Specify:	,	, , ,		Specify: Wh:	
21215-0036	72 hours after death with the Maryland naturel', or items 23e or 28e-f show dical Examinar must be notified at		15. Decedent's Education		dent's Usua	I Occupa	ition			16h Kin	d of Business/In	ndustry.
215	hin 72 b. "ne Medit	Completed	(Specify only highest grade completed	(Give 1-4or 5+)	kind of wor DO NOT us	k done d e retired,	uring most	of working	ng	TOD. KIII	a or basinessyn	idustry
21	od with	Com	2.5.11.5.11.21,7.55557.321,7 (5.12.7)	Accou	nt Exe	ecuț	ive			Adve	rtising	
nd	be fill ital Hy id oth	Be	17. Father's Name (First, Middle, Last)						(First, Middle			
Maryland	hould d Mer narke natic	2	Michael Joseph Fornator  19a. Informant's Name/Relationship (Type, Print)			/C4== =4 =					hoenfel Town, State, Zip	
Ma	nd 2 s Ith an 27 is r		Kathleen Fornatora - Wi						, MD 2		rown, State, Zij	o Code/
ē,	THeal item		20a. Method of Disposition	20b. Place of Dispo	sition (Nam	e of	I		ate 2		ation - City or To	own, State
E	Page nent o nt: if		1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from  `4 ☐ Donation 5 ☐ Other (Specify)	Ft. Linco				3/14	/2005	Bren	twood,	MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examinar must be notified at once.		21. Signature of Funeral Service Licensee	22 U-	2. Name and	Addres	s of Facility	y 170 0 70 0	al Nama	Tma		
_	20 E 2 9		23a. Part1. Enter the disease, or complications that	January 1	L800_N	ew F	lampsh	nire		1ver	Spring.	MD 20904
8760,	Physician /Medical Examiner buysician and buysician and stream transit superprise the private properties of the private pr	Ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury that initiated events cause.	fuse Cerebrova (or as a consequence of): (or as a consequence of):	ıscula	r Di	sease					* **
.O. Box 6	death certif e attending id for use a	Physician/Medical	in the past 12 months?	nant at time of death 5	Ectopic pre					23	d. Date of delive	ery Day Year
rds, P	The law requires that the site has been signed by the bage 2 should be detache	by	Part II. Other significant conditions contributing to Diabetes Mellitus	leath but not resulting in the u	nderlying ca	use give	n in Part I.			_	_	he cause of death? pably 4 Unknown
Vital Records,		Completed							24a. Was autop perfo 1 \( \text{Yes} \)	an osy rmed? 2X No	24b. Were auto prior to co death? 1 \( \subseteq \text{Yes}	opsy findings available mpletion of cause of 2 No
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?			I Otha		of Death	(Check only o	one)		
of	ding Phys h. After this funeral di	tlon; To	TE TOS ZEE NO	Inpatient 2 ER/Outpatier of Injury oth, Day Year)  28b. Time of Injury		Bc. Injury Work	4 L Nur	2	ne 5 🛣 Resid 8d. Describe I	_	Other (Specific occurred	ý)
Division	in the	Certification;	3 Suicide 6 Could not be 28e. Place	e of Injury - At home, farm, str ling, etc. (Specify)	eet, factory,	office		2	8f. Location (\$ City or Tox		Number or Rura	al Route Number,
	H 4 h	edical	29a. Certifier (Check only one)  Certifying Physician: To the 2 Medical Examiner: On the and man	e best of my knowledge, death pasis of examination and/or in- oner stated.	h occurred a vestigation,	it the time in my op	e, date and inion, deatl	d place, a h occurre	nd due to the	cause(s) a date and p	nd manner as s lace, and due to	tated. o the cause(s)
	To the To the complet	2	29b. Signature and title of certifier	nolon	OE	License 00580					signed ( <i>Month</i> , 0/2005	Day, Year)
				MD 2901 Olne	y San	dy S	pring	Rd.	Olney	, MD	20832	
	Sta Registr		31. Date filed (Month, Day, Year) MAR 1 4 2005	Registrar's Signature	le							

			1 - For State Registrar	State of M	aryland		artmen tificate			and M		giene Reg. No.	005	10464
	Physici	an.	1. Decedent's Name (First, Middle, Las	st)							2. Date of De Month	ath Dev	Year	3. Time of Death
	/Medi		Minnie I								March	12	2005	5:15 A M
4	Examir	ner	4a. Fecility Name (If not institution, give						Location o				ounty of Death	
			Fairfield Nursing		(	a b tab do A	If Under		ville		0.0		ne Aru	
т	Funeral Director		5. Social Security Number 6. S 220 05 3122	ex □M 2XSF /.∧9	ge (In yrs. Ias 86	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da Aug 12	tn ly, Year) 3 101	9. Birthi	place (State or Foreign
			Usual Residence of Decedent		00						Aug 1	2, 191	.o Ma	ryland
	/land		10a. State 10b. County		10c. City,	Town or Lo	cation							Od. Inside City Limits
	the Marylan 28a-f ehow netition at	tor	MD Howard		Co	lumbia	9							1 ☐ Yes 2X No
	or 28s	irec	10e. Street and Number				10f. Zip	Code				10g. Citizer	n of What Cou	ntry?
	72 hours elter deeth with the Maryland natural', or teme 23a or 28a-f ehow Jasal Examinet must be notified at	Funeral Director	6194 Satanwood Di	cive			2	1044				Uni	ted St	ates
	deel	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. \	Was Deced	ent of His	spanic Orig	gin? (Spe	ecify Yes or No Rican, etc.)	- 14.	Race - Americ	
9	or ft	F	1 Never Married 2 Married	1 Yes 2 X	No		Tos, spec		Specify:	, r dento	r noan, etc./		Black, White,	etc.
93	ural',	d by	3 Widowed 4 □ Divorced	Year or Dates:				- G-7,140	ороспу.			3,	pecify: Wh.	ite
215-0036	72 hours efter dee "natural", or Iteme buical Examinal m	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)		16a. Deced	kind of wor	k done d	urina most	of worki	ing	16b. Kind	of Business/In	dustry
12	within ene. than "	mp	Elementary/Secondary (0-12)	College (1-4or	5+)		DO NOT us							
121	Hygie Hygie ther t		17. Father's Name (First, Middle, Last)	тт		Lega	al Sec	creta		r's Name	(First, Middle		orney	
Maryland	s i and 2 should be filed within 72 hours efter deeth with the Maryla if Health and Mental Hygiene. Item 27 is marked other than "natural", or iteme 23s or 28s-f show other traumatic event, the Meulcal Examiner must be notified at	Be	Jacob Radeloff						Jenn			cnown	mame)	
2	hould Me Mark mark	7	19a. Informant's Name/Relationship	Type Print)		19h Mailin	a Addraes	(Street 2			al Route Numb		num Ctata Tir	Code
Z	d 2 shoth and the and the and the traum		Jerrold Fox/Son	ypo, 7 1211)										(Code)
a)	s 1 and 2 if Health item 27 other tra		20a. Method of Disposition		20b. Plac	ce ol Dispo	sition (Nam	e of	1		<u>columbia</u>		ion - City or To	own State
0	Pages Tent of Int: If it		1 Burial 2 Cremation 3			retery, cren co Cre				_1 <i>1</i> _	2005		sville	
Baltimore,			<ul> <li>4 □ Donation 5 □ Other (Specify</li> <li>21. Signature of Funeral Service Licen</li> </ul>	·										
Ba	permit. Departr Imports any inje		23a. Part 1. Enter the disease, or com	- httple	M0104	4.	112 0	ld Co	olumb	ia P	ike Ell	licott		ily FH Inc. MD 21043
8760,	Physician /Medical Examiner  This prijetrausit the prijet	lical Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. As I volume to local and the control of the cont	a conseque	nce of):	LUMO Halak							Interval Between Onset and Death
O. Box 6	death certifii e attending p id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal de	eath 3	Ectopic pre					230	. Date of delive	ery Day Year
Records, P	law requires thet the de as been signed by the a 2 should be detached f	by	Part II. Other significant conditions of	ontributing to death b	out not resulti	ing in the ur	nderlying ca	use give	n in Part I.			obacco use		ne cause of death?
S	req hou	Completed									24a. Was	/		
Re	The far	du									autop		prior to co death?	psy findings available mpletion of cause of
a	n: Ti ficate or, pa		Of Man and of the state of the								1 Yes	2 50No		21 <b>50</b> No
Vital	Physician: The law r this certificate has t ral director, page 2 s	o Be	25. Was case referred to medical examiner?  1 Yes 2 9000	Hospital:		210		Othe			(Check only o			
of	Phy this	<b>-</b>	27. Manner of Death	1 Inpatie		VOutpation 8b. Time of		A	4) Nui		me 5 Resident			y)
O	ding h. Afte fune	tior	1 Natural 5 Pending 2 Accident Investigation	28a. Date of Inju (Month, Da	ıy Year)	Injury	м	Bc. Injury Work	? es 2.⊟N			ion alignity o		
Division	l or Attending after death. Director: After in by the fune	Certification;	3 Suicide 6 Could not be determined	28e. Place of In	jury - At hom tc. (Specify)	e, farm, str					281. Location (S City or Tox	Street and N vn, State)	lumber or Rura	l Route Number,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 1 Certifying Ph	ysician: To the best niner: On the basis of and manner st	of examination	edge, death n and/or inv	occurred a	at the time in my op	e, date and inion, deat	place, a	and due to the ed at the time,	cause(s) and date and pla	d manner as s	ated. the cause(s)
	To the within 2 To the complet	₩ E	29b. Signature and title of certifier				29c	License	number			29d. Date s	igned (Month,	Day, Year)
	⊢ \$ ⊢ ō		X/1	A 4 X			-	17	200	C		7/1	11/2-	
1	2		30. Name and address of person who	/ V /	death (Item 2	3a) /Tunn	Print\	75	895	5		2 /1º	1/43	
( ) U	, , , , , , , , , , , , , , , , , , ,		Daliest Sun	ph Sill	u 14	13	Anna	bote	, h	loag	1#1	06	oclento	4 MD 21113
	Sta Registi		31. Date filed (Month, Day, Year)	32. Redistr	rar's Signatur	to do	berti	0						

Physic		1. Decedent's Name (First, Middle, I	<i>'</i>		erunca	ale oi	Death	2. Date of De		Year	3. Time of Dea
Physicia. Medic/		Frieda M. Ferr	eira					March	fð	2005	1:00 h
Examin		4a. Fecility Name (If not institution, g 9305 Millbrook					or Localion of Deat Ott City	h		ounty of Death Howard	1
Funeral Director		213-10-3934		(In yrs. last birthda 86 Yrs	Month	hs Days	If Under 24 Hrs Hours Min.	8. Date of Bird Month, Da 3/11/1	918"	9. Birth	place (State or Foi intry) aryland
land		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location						10d. Inside City Li
Mary -feh	to	Md. Howar	ď	Ellic	cott (	Citv					1 ☐ Yes 2 5
r 28a	Funeral Director	10e. Street and Number				Zip Code			10g. Citize	n of What Cou	intry?
th wit	a D	9305 Millbrook	Rd.			210	42		Ì	USA	
ems effa	Iner	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 1	3. Was De	ecedent of h	lispanic Origin? (S an, Mexican, Puer	pecify Yes or No	14.	. Race - Amer Black, White	
within 72 hours after death with the Maryland ene. than "naturel", or Items 23s or 28s-f show the Maulcal Exartitier fram be multified at	by F.	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	0		s 20 No		,			White
hour	edt	15. Decedent's		16a. De	cedent's U	Jsual Occup	nation		16h Kind	of Business/Ir	ndustry
n "ne	Completed	(Specify only highest of	grade completed)	(G.	ive kind of e. DO NO	work done T use retire	during most of wo. d)	rking	100.11110	01 20011033411	loustry
d with	E	Elementary/Secondary (0-12)	College (1-4or 5+	+)	Home	emake:	r			Home	
be filed tal Hygi d other event, I	Bec	17. Father's Name (First, Middle, La						me (First, Middle,		ımame)	
should bent and Ments smarked	2	William Geb	elein				Emma	a Kaste	n		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "naturel", or Items 23a or 28a-f show any injury or other treumetic event, the Maulcal Examiner mail be notified at once.		19a. Informant's Name/Relationship Carolyn Barnes		19b. Ma 305	ailing Addre	ess (Street echt	and Number or Ru Rd. Sykes	ral Route Number Sville, Mo	r, City or T 1. 21	own, State, Zi 784	p Code)
is 1 a of Hea item othe		20a. Method of Disposition		20b. Place of Dis	sposition (f	Name of	ce)	Date	20c. Loca	tion - City or T	own, Slate
Pages nent of int: If its iry or o		1 ABurial 2 ☐ Cremation 3 14 ☐ Donation 5 ☐ Other (Spe					etery 3/1	L6/2005	Wood.	lawn,Md	1.
permit. Departm Importa any inju		21. Signature of Funeral Service Lie	ensee	1500045	22. Name	and Addre	ss of FacilityHa	cv H.Wi	zke!	s Famil	v F.H.T
89559		mone P.C	malo	MOO845	4112	old (	Columbia	Pike El	licot	t City.	Md. 2104
		23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused the one cause on each line	the death. Do not	enter the m	node of dyir	ng, such as cardia	or respiratory ar	rest,	-	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition		10 card							Onset and Dea
/Medical Examiner		resulting in death)		consequence of):		-					
Examine	_	Sequentially list conditions,	b								
ed sit	lhe	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):							
te be executed ysicien and te burial-transit	Examiner	thal initiated events resulting in death) Last	cDue to (or as a	consequence of);							
be e sicien buria	calE										
ficate physics the	oppe		a								
The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o						230	d. Date of deliv	ery
that the death cert ed by the attendin detached for use	Cla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 2 4□Pregnant at t		3 ∐Ect <i>o</i> pio 5 ☐ Other	c pregnancy (specify)	<i>'</i>			Month	Day Year
by the	hys	9 Unknown	9 Unknown								
tw requires that s been signed b should be deta	y P	Part II. Other significant conditions	A .	1	a underlyin	ig cause giv	en in Part I.	23e. Did to	bacco use	contribute to t	he cause of death
en sig	ed	1-1/ pertenurs.	, Asthum	100/1	)			1 🗆 Y	es 2 🗔	√o 3 □ Prol	bably 4 Unk
aw re	Completed							24a. Was		24b. Were auto	opsy findings ava
The lay	E							autop perfor	med?	dealh?	ompletion of caus 2□ No
	Be C	25. Was case referred to medical					26. Place of Dea	ath (Check only o		7.2.100	20110
nysic lis ce direc	10	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatien	t 2 ER/Outpat	tient 3	DOA Oth	er: 4 Nursing H	lome 5 Resid	ence 6	Other (Special	fy)
Attending Physician: r death. ector: After this certifici		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Dale of Injury (Month, Day	Yeer) 28b. Time		28c. Injur Wor	y at k?	28d. Describe h	ow injury o	ccurred	
endis sath. or: Al	atle	2 Accident investigat	ion		M		Yes 2 □ No				
or Att	Certification:	3 Suicide 6 Could not 4 Homicide determine	28e. Place of Injurbuilding, etc.	ry - Al home, farm, (Specify)	street, fact	tory, office		28f. Location (S City or Ton	treet and N n, State)	lumber or Run	al Route Number,
To the Hospital or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	edical Ce	29a. Certifier 1 Certifying	Physician: To the best of aminer: On the basis of a	f my knowledge, de	ath occurr	red at the tir	me, date and place	, and due to the c	ause(s) an	d manner as s	stated.
To the H within 24 To the F complete	Medi	one)	and manner state	ed.							
To To con	-	29b. Signature and title of certifier			1	29c. Licens	e number		29d. Date s	igned (Month,	
To design the second		1 auch	hlog				217/2	8	3	11/0	5
	. !	30. Name and address of person wh	o completed cause of de-	ath (Item 23a) (Typ	e, Print)						
7	1										

		For State	State of Maryland	d / Depa		h and Me	ental Hygie	ene <sub>2005</sub>	10466
		Registrar			illicate of Dea			. No.	0 F 4D
Physic	ian	Decedent's Name (First, Middle, Last)	2 - 1	1		1	2. Date of Death Month	Day Year	3. Time of Death
/Med				eley			March	13 2005	
Exami	iner	4a. Facility Name (If not institution, give stre	et and number)	,	4b. City, Town, or Locati	ion of Death		4c. County of Deat	h
		Harford Memor	ial Hospital		Havre de			Harf	ord
Funera	1	5. Social Security Number 6. Sex	7. Age (In yrs. I		If Under 1 Year If Under 1 Year House	ider 24 Hrs.	8. Date of Birth (Month, Day, Y July 10,	9. Birt	hplace (State or Foreign untry)
Directo	r	227-20-4004	2 <b>X</b> F 77	Yrs.			July 10,	1927	Virginia
D		Usual Residence of Decedent	100 000						
anyla shov		10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
e Mi	9	Maryland Cecil			Perryvil	lle			1⊠Yes 2□No
th th	Jire	10e. Street and Number			10f. Zip Code		100	. Citizen of What Co	untry?
11 will	Funeral Director	2 Ellis Court			219	03		U.S.	. A .
dea	ner	11. Marital Status 12.	Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of Hispanic f Yes, specify Cuban, Mex	Origin? (Spec	cify Yes or No-	14. Race - Ame	
o after of the control of the contro	교	1 Never Married 2 Married	1 ☐ Yes 2 ☒ No If Yes, Give		1 ☐ Yes 2⊠ No Spec		noan, otc.)	Black, White	e, etc.
Surs Surs	by	3 △ Widowed 4 □ Divorced	Year or Dates:		10 165 22 NO 3pec	uny.		Specify:	White
72 hc	Completed	15. Decedent's Educat (Specify only highest grade of	ion omn/eted)	16a. Dece	dent's Usual Occupation	most of workin	16	b. Kind of Business/	Industry
Hin .	gid	Elementary/Secondary (0-12)	College (1-4or 5+)	/ife.	kind of work done during r DO NOT use retired)	most of working	g		
M d w	0	Eleven Years			Homemaker			Personal	Residence
If yielled Z LZ I 3-0030 should be filed within 72 hours after death with the Maryland nd Mental Hygiene, marked other then "natural", or Items 23e or 28e-f show imatic event, the Modical Examiner must be notified at	Be (	17. Father's Name (First, Middle, Last)			18. Ma	lother's Name	(First, Middle, Ma	iden Sumame)	
E d bid by the state of the sta	To	James Emmett	Sapp				Carrie	Burgess	
shound North		19a. Informant's Name/Relationship (Type,	Print)	19b. Mailir	ng Address (Street and Nu	mber or Rural	Route Number, C	City or Town, State, 2	Zip Code)
IVIC nd 2 Ifh a 127 Is	1	J. Randolph Fadeley	(son)	L.	Woodberry Dr.				0809
Head The		20a. Method of Disposition	20b. P	ace of Dispo	sition (Name of natory or other place)	, Da	ate 20	c. Location - City or	Town, State
ages of of the life of the lif		1 ☑ Burial 2 ☐ Cremation 3 ☐ Rem	ioval itolii State			00/7			
t. P.		`4 □ Donation 5 □ Other (Specify)	As		Cemetery	03/1	//U5 P	ort Deposi	it, Maryland
partitioner, Intal ylatific 2.12.13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Imp. rient: If Item 27 is marked other then "natural; or Items 23e or 28e-f show any njury or other treumatic event, the Modical Examiner must be notified at once.		21. Signatifie of Funeral Service Licensee	ELLERDON, &	~ L	Name and Address <i>of</i> Fa ee A. Patter erryville, M	son & :			P.A.
Dhoristan		23a. Part1. Enter the disease, or complicat shock, or heart failure. List only one of Immediate Cause (Final						Ι,	Approximate Interval Between Onset and Death
Physician /Medical Examiner	1	disease or condition resulting in death)	A cute M Due to (or as a consequ		MAT IN	farc.	lion		10 year 5
	e l	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c	Due to (or as a sonsequ	ance of):	tery Dis	ease			. 100
ried last	Examiner	cause. Enter Underlying Cause (Disease or injury	ها مماه آن	c 1	1 all the s				30 years
te be executed ysician and le burial-transit	Xai	that initiated events resulting in death) Last	Due to (or as a consequ	ence of):	(E(M) 4)				10.19
e be e sician b burië	calE		4						
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OX O	Physician/Med	IF FEMALE:	If yes, outcome of pregnal	nov					
ath c	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Fetal	death 3	Ectopic pregnancy			23d. Date of deli Month	very Day Year
the de	/sic	1 ☐ Yes 2 🖾 No 9 ☐ Unknown	4☐Pregnant at time of de 9☐ Unknown	atn 5L	Other (specify)	<del></del>			•
d by	P.		- Alamah busana	Minn in the			One Did toba		46
vital neconds, F.O. box oo rou, idea: The law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit	ed by	Part II. Other significant conditions contril	butting to death but not resu	ming in the u	nderlying cadse given in Fa	anı.	1 ☐ Yes	cco use contribute to	obably 4 Unknown
aw re	Completed						24a. Was an	24b. Were au	topsy findings available
he la e ha	E						autopsy performe	d3 death?	completion of cause of
vital icien: T certificat ector, p	O	25. Was case referred to medical			00 DI	Union of Dooth	1 Yes 2	1 Yes	2 □ No
sicie cert rect	o B	examiner?	pital:		Other		(Check only one)		
SION OI VITA tending Physicien: leath. tor: After this certific the funeral director,	-	10 163 20 140	28a. Date of Injury	28b. Time of	I 3 DOA   4L		le 5 ∐ Residend 8d. Describe how	e 6 Other (Spec	cify)
After fune	lo	Natural 5 ☐ Pending	(Month, Day Year)	Injury	Work?		od. Describe now	injury occurred	
Sicond Seath Seath Sor:	cat	2 Accident investigation 3 Suicide 6 Could not be							
or Attending after death. Director: Afte in by the fune	Certification:	4 Homicide determined	<ol> <li>Place of Injury - At ho building, etc. (Specify</li> </ol>	me, farm, str	eet, factory, office	2	8t. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
re led ii									
To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certification completely filled in by the funeral director,	edical	29a. Certifier Check only one) Certifying Physici	ian: To the best of my know : On the basis of examinat and manner stated.	wledge, death ion and/or in	n occurred at the time, date vestigation, in my opinion, o	e and place, as death occurre	nd due to the caus d at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
To th withir To th somp	Me	29b. Signature and title of certifier	4	-	29c. License numb			. Date signed (Month	
		> XXV		D	000	5745	56 4	larch 13,	2005
0		30. Name and address of person who comp	pleted cause of death (Item adtes, 501	23a) (Type,	Print)				
	tate	Dr. Date filed (Month Day Vens)	20 Desistanda Cinna			ue, nav	Te de G	ace, MD	21078
Regis	trar	MAR 1 5 2005	Slow If	A COSA					

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Dix

		For State Of Maryland 7 to State Registrar  Decedent's Name (First, Middle, Last)	Certificate of Death	2.	Re Date of Deat Month		3. Time of Death
Physician /Medical Examiner	4	Robert Bernard Forbe a. Facility Name (If not institution, give street and number) VA Maryland Health Care System	4b. City, Town, or Location Perry point	of Death	arch	11 200 4c. County of De Cecil	
Funeral Director	ctor	. Social Security Number 16. Sex 1 M 2 ☐ F 7. Age (In yrs. last bit 1 M 2 ☐ F 83	thday) If Under 1 Year If Under Yrs. Months Days Hours	Min.	Date of Birth (Month, Day, uly 12	9. B (2, 1921 P	irthplace (State or Fore Country) ennsylvania
Ra-f show		Journal Residence of Decedent     Oa. State	Conowing	go			10d. Inside City Lim 1 ☐ Yes 2 🖔
23g or 2		0e. Street and Number 775 Ragan Road	10f. Zip Code 219	18	11	0g. Citizen of What 0	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If Itam 27 Ia marked other than "netural; or Itams 23a or 28a-f show amportent: If Itam 27 Ia marked other than "netural", or Itams 23a or 28a-f show amportent in June 1 and 1 and 1 and 1 and 2 a	Di La la	11. Marital Status  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married  1 □ X Yes 2 □ No  1 □ X Yes 2 □ No  1 □ X Yes 3 □ No  1 □ Yes, Give  Year or Dates: 1942-70	13. Was Decedent of Hispanic Or If Yes, specify Cuban, Mexical  1 ☐ Yes 2 ☒ No Specify:		Yes or No- an, etc.)	14. Race - An Black, Wh Specify:	
led within 72 hou lygiene. nar than "netura it, the Medical E	niplete.	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during mos life. DO NOT use retired)  Security Office			16b. Kind of Busines Secur	·
of be filed wintal Hygie ed othar t	ם ב	Twelve Years  17. Father's Name (First, Middle, Last)  Harry F. Forbes				Maiden Sumame) Gillespie	TLY
d 2 should I th and Men it and Men it I amarken treumatic		19a. Informant's Name/Relationship (Type, Print) 19th	o. Mailing Address (Street and Number) 98 Coebourn Blvd.		oute Number,	, City or Town, State	Zip Code)
Pages 1 an nent of Heal int: If Itam 2 iry or othar	-	20a. Method of Disposition 20b. Place of State 2 Comments	f Disposition (Name of ry, crematory or other place) con of Drexel Hill	Date 03/21/		20c. Location - City of	
permit. Departm Importe any inju		21. Signature of Funeral Service Licensee	22. Name and Address of Facili Lee A. Patters Perryville, Ma			eral Home 03-0766	, P.A.
nysician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  a. Pneumonia Due to (or as a consequence		s cardiac or re	spiratory arre	est,	Approximate Interval Between Onset and Death Unknown
ifficate be executed was the burial-transit as the burial-transit bedical Examiner	LAG	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last  b. Due to (or as a consequence c					
w requires that the death certificate be been signed by the attending physici should be detached for use as the bushed by Dhystolan/Medical	lysicial vineal	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   Unknown   Unknown   23c. If yes, outcome of pregnancy 1   Live birth 2   Fetal death 4   Pregnant at time of death 9   Unknown	3 ☐Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of d Month	elivery Day Year
quires that an signed b uld be deta	ב <u>ל</u>	Part II. Other significant conditions contributing to death but not resulting Prostate Cancer	n the underlying cause given in Part	l.			to the cause of death' Probably 42 Unkno
The law requir cate has been s page 2 should	naidillo	Hypertension			24a. Was an autops perform	v prior to	autopsy findings availa o completion of cause of es 2 <b>K</b> No
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funaral Diractor: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Medical Certification: To Be Completed by Physician/Medical Examily	0	27. Manner of Death 1 X Natural 2   Accident   S   Pending   28a. Date of Injury (Month, Day Year)   28b.	other: 4 🕅 Nother: 4 🛗 Nother: 4 🗂 Nother: 4 🗂 Nother: 4 🗂 Nother: 4 🗂 Nother: 4 🗂 Nother: 4 🗂 Nother: 4 🗂 Nother: 4 🗂 Nother: 4 🗂 Nother: 4 🗂 Nother: 4 🗂 Nother: 4 🗂 Nother: 4 $\prod$	28d	5 🗌 Reside	e) ence 6 Other (Sp ow injury occurred	ecity)
urs after daral Diract	Ceruit	3 Suicide 4 Homicide Could not be determined  28e. Place of Injury - At home, fe building, etc. (Specify)			City or Town		
To the Hospital within 24 hours a within 24 hours completely filled completely filled	vedica	29a. Certifier (Check only one)  2 Medical Examiner: On the basis of examination and manner stated.	nd/or investigation, in my opinion, dea	nd place, and ath occurred a	at the time, da	ate and place, and di	ue to the cause(s)
with To Con	2	29b. Signature and title of Continer	29c. License number D19402		2	9d. Date signed <i>(Moi</i>	nth, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

State of Maryland /	Department of	f Health and Mental	ŀ
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I	Physici	an	1. Decedent's Name (First, Middle, Last)  2. Date of Dea Month								
	/Medid		4a. Facility Name (If not institution, give s			4b. City, Town, or	Location of Death	Parcii	4c. County of		11:30 A
			Salisbury Nursing				Salisbur		Wicom		
	Funeral Director		213-10-000/	M 0075	thday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Bir (Month, Da 01-05-	th ly, Year) 1921	9. Birthpl Count MARY	ace (State or Foreign try) LAND
	and	-	Usual Residence of Decedent  10a. State 10b. County	10c. City, Tow	n or Loc	cation				10	0d. Inside City Limits
	Maryl	to	MD WICOM	ICO SALIS	RHE	V					1 ☐ Yes 2 No
re, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours atter death with the Maryland Heath and Mental Hygiene. item 27 is marked other then "neturel", or Iteme 23a or 28e-1 show other treumatic event, the Medical Evantral must be rediffied at	h the	Director	2 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country							try?	
	23a c	aiD	102 JEROME DRIVE				21804			USA	
	rs after des I', or Iteme	Completed by Fur	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	I2. Was Decedent Ever in U.S. Armed Forces? 1∑Yes 2☐No 1942— If Yes, Give Year or Dates: 1945	If	Vas Decedent of His Yes, specify Cubar ☐ Yes 2 No	spanic Origin? (Spanic Origin? (Spanic Origin? (Spanic Origin) (Spacify:	cify Yes or No Rican, etc.)		- America k, White, e	
	thin 72 hou e. en "neture Medical E		15. Decedent's Educ (Specify only highest grade	cation 16a.	(Give I	lent's Usual Occupa kind of work done di DO NOT use retired)	uring most of worki	ng	16b. Kind of Bus	iness/Ind	lustry
	ed wii ygien yer th			4		AUDITOR				ERAT:	IVE
and	ould be fil Mental H arked oti atic even	Be c	17. Father's Name (First, Middle, Last)	FNV			18. Mother's Name			"	
Battimore, Maryland permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: if item 27 is marked oth any injury or other treumatic event	should od Me mark mark	<u>د</u>	WILLIAM ANDREW GEM  19a. Informant's Name/Relationship (Ty)		. Mailin	g Address (Street a	HENRIETT <i>A</i> nd Number or Rura			State, Zip	Code)
	alth ar 27 is ar treu		SUSAN GEMENY - SPO	USE Daughter P.	0.	BOX 74, K	EEDYSVILI	LE, MAR	YLAND 21	756	
	of Head		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ R	20b. Place o	f Dispos	sition (Name of natory or other place	)	ate	20c. Location - 0	City or To	wn, State
Ĕ	Pag Iment tent: I jury o		' 4 ☐ Donation 5 ☐ Other (Specify)	SPRING		L MEM. GD					
Bal	permit Depar Impor any in	, y:	21. Signature Tuperal Service License	Lung	70.	Name and Address  EAST MA	IN STREET	SALIS,	BURY, MAR		
/Medica			23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death								
	Physician (Modical		Immediate Cause (Final disease or condition resulting in death)	Alzhamo	-	emanh	લ			7	Zyens
	Examiner			Due to (or as a consequence	of):						
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence	of):						
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38760,	ficate be executed physician and s the burial-transit	dicai Ex	resulting in death) Last	Due to (or as a consequence of):							
~	rtificate ng phy as the	w	IE EEMALE.								
S, P.O. Box 6 es that the death certif igned by the attending be detached for use as	ie death cei the attendir hed for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown		Ectopic pregnancy Other (specify)			23d. Date Mon		ry Day Year
α.	that the	y Ph	Part II. Other significant conditions cor	ntributing to death but not resulting i	n the ur	nderlying cause give	n in Part I.	23e. Did 1	tobacco use contri	bute to th	e cause of death?
rds	quires an sign	ed by						1 🗆	Yes 2 No	3 🔲 Proba	ably 4 □Unknown
Division of Vital Records, P.O. Box ( Hospital or Attending Physician: The law requires that the death certif Fu hours after death. Fu hours after death. Fu hours after death. Fu hours after be the children has been signed by the attending tely filled in by the funeral director, page 2 should be detached for use a	The law re ite has bee	Completed				<u> </u>		24a. Was auto perfo	psy pr	rior to сол eath?	psy findings available inpletion of cause of 2 No
	clen: artifica actor. I	BeC	25. Was case referred to medical examiner?				26. Place of Death				
	hysio this or al dire	ဥ	1 □ Yes 2 ☑ No	lospital: 1 Inpatient 2 ER/O			41 - Tursing Hor		idence 6 Othe		)
	ding F h. After funera	tion:	27. Manner of Đéath  1 ☑Natural 5 ☐ Pending  2 ☐ Accident investigation		Time of Injury	Work	at ? ′es 2 □ No	28d. Describe	how injury occurre	М	
	l or Atten after deat Director:	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, fa building, etc. (Specify)	arm, stre			28f. Location ( City or To	Street and Numbe wn, State)	r or Rura	l Route Number,
	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	edical Ce	29a. Certifier (Check only one) Certifying Physical Exami	sician: To the best of my knowledg ner: On the basis of examination ar and manner stated.	e, death	occurred at the tim restigation, in my op	e, date and place, a pinion, death occurr	and due to the ed at the time,	cause(s) and man date and place, a	iner as str nd due to	ated. the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier			29c. License	number		29d. Date signed	(Month, I	Day, Year)
	JR.		R ADERDY N	YD QY		000	61688		03/15/6	5	
	1090		30. Name and address of person who co	2.0			, chest	n MD	21619		
*	Sta Regist	ate rar	31. Date filed (Month, Day, Year) MAR 1 6 2	32. Registrar's Signature		South ,	,				
	licgist	8 . A		CONTRACT OF							

			1 - For State Registrar	State of Marylan		rtment of F		-	giene nog. No.2005   10469
	Physici /Medic		1. Decedent's Name (First, Middle, Las DIMITRIOS	GEORGOPO	ULOS			2. Date of De Month MARCH	ath Day Year 3. Time of Death
	Examir		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of De	ath	4c. County of Death
			Montgomery General 5. Social Security Number 6. Se		last hidhdaul	Olney	If Under 24 H	rs. 8. Date of Bir	th y, Year) 9. Birthplace (State or Foreign Country)
	Funeral Director			2 F 50	Yrs.	Months Days	Hours M		y Year) Lamia, Greece
	ryland		10a. State 10b. County	10c. Cit	ty, Town or Lo	cation			10d. Inside City Limits
	Se-f s	Director	Maryland Montgor	nery Si	lver Sp				1 ☐ Yes 2 No
	e or 2	Dir	10e. Street and Number	Doubon		10f. Zip Code	205		10g. Citizen of What Country?
	Jeath	Funeral	16513 Harbour Town	12. Was Decedent Ever in U	J.S. 13. V		905 Iispanic Origin?	(Specify Yes or No erto Rican, etc.)	USA 14. Race - American Indian,
36	hin 72 hours after death with the Maryland e. en "netural", or Items 23e or 28e-f show Medical Examinar must be motified at	by Fur	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give		Yes, specify Cuba □ Yes 2, No	an, Mexican, Pu Specify:	erto Hican, etc.)	Black, White, etc.  Specify: White
21215-0036	2 hour	ed b	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Ed	Year or Dates:	16a. Deced	lent's Usual Occup	pation		16b. Kind of Business/Industry
215	within 72 ene. then "nei	Completed	(Specify only highest gra Elementary/Secondary (0-12)	de completed)  College (1-4or 5+)	(Give	kind of work done OO NOT use retire	during most of v	vorking	,
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Maryland	e a a	) Be	17. Father's Name (First, Middle, Last)  Paylos Georgon	20120					, Maiden Sumame)
aryl	es 1 and 2 should b of Health and Ment litem 27 is marker r other treumatic	ဥ	19a. Informant's Name/Relationship (7		19b. Mailin	g Address (Street	Georgi and Number or		aragousa er, City or Town, State, Zip Code)
	1 and 2 Health a tem 27 is		Yaritza Georgopou	ılos / Wife	16513	3 Harbour	Town I	rive Sil	ver Spring,MD 20905
altimore,	Pages 1 and of He		20a. Method of Disposition 1 ♣ Burial 2 ☐ Cremation 3 ☐	nemoval Itulii State	Place of Dispos cemetery, cren	sition (Name of natory or other place	сө)	Date	20c. Location - City or Town, State
tim	t. Pag ntment rtent: njury o		`4 ☐Donation 5 ☐ Other (Specify	Ga	te of I				Silver Spring, Maryland
Bal	permit. Pages Department of I Importent: If it eny injury or of		21. Signature of Funeral Service Licen	See Cu Su					aldi Funeral Home ilver Spring, MD 20904
	Physician /Medical Examiner	ner	23a Part1. Enter the disease, or com, shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter the characteristics of the cause (Disease or injury)	a	E M quence of):	60000 7110			rrest, Approximate Interval Between Onset and Death TEN MIN
,0928	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the buriat-transit	dical Examine	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a consect d	quence of):				
.O. Box 6	that the death certific ed by the attending pi detached for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of pregnative birth 2 ☐ Feta 4 ☐ Pregnant at time of continuous forms of the second of the s	al death 3 🗆	Ectopic pregnanc Other (specify)	<b>y</b>		23d. Date of delivery Month Day Year
rds, P	quires that on signed build be det	by	Part II. Other significant conditions o	ontributing to death but not res	sulting in the ur	nderlying cause giv	en in Part I.		obacco use contribute to the cause of death?  Yes 2 No 3 Probably 4 Munknown
al Records,	The ate h page	Completed						24a. Was auto perfo 1 Ves	
Vital	Physicien: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	Hospital:	<b>Y</b> =D/O		100	Death (Check only	
of		<b>-</b>	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	I JL DOA	4 La Mursini		dence 6 Other (Specify) how injury occurred
Division	ten leat tor: the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide		iome, farm, str	M 1 🗆	Yes 2 □ No	28f. Location (	Street and Number or Rural Route Number, wn, State)
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	To the H within 24 To the Fi complete	Me	29b. Signature and title of certifier	10		29c. Licens	se number		29d. Date signed (Month, Day, Year)
	10		▶ Calgarhai	eg MD		D00	0605	95	MARCH, ELEVENTH, 2005
	( -		30. Name and address of person who	completed cause of death (Iter	m 23a) (Type,				
			C.A. Gerhardt, M. 31. Date filed (Month, Day, Year)	D. 18101 Pri	nce Ph	ilip Driv	re Olney	,Marylan	d 20832
	St Regist	ate rar	MAR 14 200		Coan	W .			

	1	State of Maryland / Department of He State of Maryland / Department of He Registrar  Certificate of D			ene 005	10470
		I. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
Physiciai /Medica		Toni Marie Gascoyne		March 11		7:00A. M
Examine		Sa. Facility Name (If not institution, give street and number)  Collegeview Nursing Home  4b. City, Town, or the street and number)	Location of Death erick		4c. County of Deat Freder:	
Funeral Director		5. Social Security Number 6. Sex 1 Months Days 7. Age (In yrs. last birthday) 1 Months Days 7. Age (In yrs. last birthday) 1 Months Days 1 Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y March 31	'ear) Co	hplace (State or Foreign untry) aryland
Maryland a-f show lifed at		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  Maryland Frederick Middletown				10d. Inside City Limits 1 2 Yes 2 ☐ No
or 28g	Directo	10e. Street and Number 10f. Zip Code		100	g. Citizen of What Co	ountry?
238 c	<u>8</u>	104 Prospect Street 2176			U.S.A.	dean Indian
be filed within 72 hours after death with the Maryland tall Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examination in the notified at	Completed by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married It Yes, Give Year or Dates:  13. Was Decedent of His If Yes, Specify Cubar It Yes, Give Year or Dates:	spanic Origin? (Sp Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)	Bfack, Whit	
id within 72 hours aff giene. er than "natural", or the Wedical Exami	npleted	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	uring most of work	ting	6b. Kind of Business	
filed wit Hygien other the	5	12 Payrol1 technic		e (First, Middle, Ma		of Energy
d be file	To Be	17. Father's Name (First, Middle, Last) Edward Bea11	Victoria		aldeli Sumame)	
es 1 and 2 should be file of Health and Mental Hy filem 27 is marked oth	ř	19a. Informant's Name/Relationship (Type, Print)  Peter Gascoyne – husband  19b. Mailing Address (Street at 104 Prospect Street At 104 Pr	nd Number or Rur treet, M	ral Route Number, ( iddletown	City or Town, State, . Marylan	Zip Code) d 21769
tea E	1	20a. Method of Disposition  1  Burial 2 Cremation 3 Removal from State  1 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Frederick Cremator	9)		oc. Location - City or	
permit. Pages 1 Department of 1 Importent: If ite any injury or ot once.		21. Signature of Funeral Service Licensee 22. Name and Address 1621 Opossu	36		neral Hom erick, Mar	
icate be executed  Examiner  Examine	icai Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):				m.sys.
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rsician: T s certificate director, ps	Bec	25. Was case referred to medical examiner?	100 miles	th Check on one		
Physician: r this certifica	္	1 ☐ Yes 2 ☑ No ☐ HOSpittal. 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	4 M 1401 311 M 11	lome 5 Resider 28d. Describe hor	nce 6 Other (Spa winium occurred	ecify)
To the Hospitel or Attending Physician: The I within 24 hours after death.  To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	Certification:	# To Setup 5 Pending (Month, Day Year) Injury World	k? Yes 2 □ No		reet and Number or F	Rural Route Number,
the Hospitel of the 24 hours at the Funerel Dippletely filled in	Medical Ce	29a. Certifier  (Check only one)  29a Certifying Physician: To the best of my knowledge, death occurred at the tin (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my or and manner stated.	ne, date and place pinion, death occu	n, and due to the ca arred at the time, da	iuse(s) and manner a ate and place, and du	as stated. ue to the cause(s)
To the within 2 To the comple	Mec	29b. Signature and title of certifier 29c. Licens		29	3/11/05	nth, Day, Year)
9		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			/	
Sta	te	30. Name and address of person who completed datase of death (rem. 200) (1)person who completed datase of da	alle term p	0 21167		
Registi		MAIN I D COOL				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend item 16b per fh 8841 3-28-05 vt
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year 555 M Marr 22 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Memorial Laston tospita The albo last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months Days 1 M 2 F Hours Min 212-03-399 Yrs. Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits other treumatic event, the Medical Examinar must be notified at 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 505 WE AVENUE 21632 or Items 23a Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No 21215-0036 Specify WHITE Completed by Specify: 3 Widowed 4 □ Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) own home Hygiene. illed within Elementary/Secondary (0-12) College (1-4or 5+) HUMEMAKER Pages 1 and 2 should be filed venent of Health and Mental Hygie ant: If item 27 is marked other t land 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Sumame) Be MEDFORD ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HAINES TRIPE 508 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of h Important: If ite any injury or of once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State HILLCREST CEMETERY 8 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee permit (6,1110) 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition ARDION **Physician** /Medical resulting in death) Due to (gras a consequence of): Examiner 15 NRS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exar iner The law requires that the death certificate be execu ed the burial-tran and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical use as IE FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year 5 Other (specify) detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 2 ☑ No 1 ☐ Yes 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? 1 Yes 2 No Z No or Attending Physiclen: ector, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA funeral dir 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident the f Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire lilled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Zi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiei Medical completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3 MARCH 22 6-30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IDLEWILD AVENUE EASTON, MD FRIEDMAN 31. Date filed (Month, Day, Year) Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

MAR 2 8 2005

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03	rel', o	i by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give 22 Year or Dates:			1 Yes 2	₩ No	Specify:			4	Specify:	White	
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Baltimore,	permit. Pages Department of Important: If it eny injury or o		21. Signatur of Funeral Service Lie	111							rge P. : d Rd. E				
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			30. Name and address of person who How Bold Vor	to completed cause of completed Cause of Cause of Cause of	leath (Iter	n 23a) (Туре, С1 V		Par	Ray	en A	mapol	45	MD	2140	21
	Sta Registi	100	31. Date filod (Month, Day, Year)	05 2. Registr	rar's Signa	ature	<b>C</b>			7					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Hancock 1:50 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number or Location of Death Examiner WRITA If Under 24 Hrs. 8. Date of Birth (Month, Day, You Jan. 11, Social Security Number 7. Age (In yrs. last birthday)
79 Yrs. Yeár 9. Birthplace (State or Foreign Year) 1926 **Funeral** Days 1**X** M 2□ F Min 500-24-6976 Missouri Director Usual Residence of Decedent 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be litted within a concentration of Health and Menial Hygiene.

Department of Health and Menial Hygiene.

Important: if Item 27 is marked other then "netural", or Items 23e or 28e-1 show important: if Item 27 is marked other then "netural", or Items 23e or 28e-1 show eny injury or other traumatic event, the Modical Expriner must be notified at once. 10d. Inside City Limits Chevy Chase 1X☐Yes 2☐No Director Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20815 5600 Wisconsin Avenue \$1106 United States Funeral 12. Was Decedent Ever in U.S. Agned Forces?
1∆∑Yes 2 □No 1944—
If Yes, Give Year or Dates: 1946 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Dentist Private Practice 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Clifford Alphonso Hancock, Sr. Caroline Eva Marshall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elaine Hancock (Wife) 5600 Wisconsin Ave. #1106, Chevy Chase, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Rock Creek Cemetery 3/12/05 Washington, D.C. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility McGuire Funeral Service nne 7400 Georgia Ave. N.W., Wash. D.C. 20012 23a. Part1. Enter the disease, or complication hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician anaplastic astrucytuma 10 month /Medical Due to (or as a consequence of): **Examiner** week umonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine Hospitel or Attending Physician: The law requires that the death certificate be executed burlal-transi Troke that initiated events resulting in death) Last and Due to (or as a consequence of) Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown ρ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ŽÜnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 2 No certificate 2 🗆 No 1 ☐ Yes 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. neret Director: A filled in by the fu investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide within 24 hours a To the Funeret L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 14 2005 Registrar

	1	1 - For State Registrar Amend#26.  1. Decedent's Name (First, Middle, 1)	Per Phys	PGC3-	.na / Dep. 	rtifica	te of	Death	and W		Reg. No	Tre (1)	05	1047
Physici /Medic		Decedent's Name (First, Middle, Josephine Barb								2. Date of De Month March	Da	, 005_	Year	3. Time of Death 9:20 P. N
Examin	er	4a. Facility Name (If not institution, g		imber)		4b. City	, Town, o	r Location	of Death		4c	. County	of Death	
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Funeral Director		579-42-7207	.Sex 1 □ M 2 1 F	7. Age (In yr.	s. last birthday) Yrs.	Months	Days	If Under Hours	Min.	8. Date of Bi (Month, D 7/24/	rth ay, Year) 34		9. Birthpl Count Balt	lace (State or Foreig try) , Md.
permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23e or 28e-1 show any injury or other traumatic event, the Medical Evantrational Evencities at ADRE.	Director	Usual Residence of Decedent  10a. State  10b. County  Md. P.G.		10c. (	City, Town or Lo		ton						10	0d. Inside City Limits
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d 2 sho th and 7 Is mu traum		19a. Informant's Name/Relationship Joyce C. Johnson		r						Route Numb				Code)
1 an Heal em 2		20a. Method of Disposition	Place of Disp	9 89th Ave., New Carrollton, Md					Location - City or Town, State		wn State			
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To the Hospital or Attending Physician: within 24 horus after death.  To the Funeral Diractor: After this certific completely filled in by the funeral director.	Certification;	3 Suicide 6 Could no 4 Homicide determin	t be 28e. Place	e of Injury - At ding, etc. (Spe	home, farm, st	reet, facto				28f. Location City or To			or Or Rural	Route Number,
a Hospita 24 hours a Funeral etely filled	edical C	29a. Certifier 1/2 Certifying (Check only one)  1/2 Certifying 2 Medical Ex	Physicien: To the and ma	ne best of my k basis of exami	nowledge, dear nation and/or in	th occurred execution	at the tir	ne, date an pinion, dea	nd place, a ath occurre	and due to the	cause(s , date and	) and mar d place, a	nner as sta nd due to	ated. the cause(s)
To the within To the	Me	29b. Signature and title of certifier				29	c. Licens	e number			29d. Da	te signed	(Month, E	Day, Year)

State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

31. Date filed (Month, Day, Year) MAR 1 4 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8AMatri

SOBHAN MATHEW,

3048 MITCHELLVILLE ROAD, BOWIE,

D47604

MD 20716

08/2005

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** JACKSON В. JR. MARCH PEYTON 2005 8:10 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's 1510 3rd Street Lanham If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months 1 M M 2 □ F 78 19 1926 New Jersey Director 128-16-4442 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show the Modical Examiner must be notified at 1X Yes 2 □ No Prince George's Lanham Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1510 3rd Street Items 23a 20706 U.S.A. Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12, Was Decedent Ever in U.S. Armed Forces? 1 型Yes 2 □ No Army 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or iter any injury or other treumatic event, the Madical Examinat 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 2+ Government Computer Analyst 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Peyton B. Jackson Sr. Clare Carey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4004 Cleary Court Bowie, Maryland 20721 Peyton J. Jackson/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 IXCremation 3 ☐ Removal from State 3/10/05 4 ☐ Donation 5 ☐ Other (Specify) Riverdale, Maryland Riverdale Crematory 22. Name and Address of Facility J. B. Jenkins Funeral Home 21. Signature of Funeral Service Licenses Manha 7474 Landover Road Landover, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) COLOW Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury Due to (or as a consequence of). Examiner To the Hospitel or Attending Physician: The law requires that the death certificate be executed anding physicien and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No. detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by been signe should be d 3 Probably 4 Unknown 1 Yes 2X No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an page 2 autopsy performed? 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ဥ 1 ☐ Yes 2 X No 28c. Injury at Work? funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: After Injury 1 X Natural 5 Pending efter death.

I Director: Af
d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Funarel Dir. 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of as D18219 March 9, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1221 Mercantile Lane Largo, Maryland 20774 Stephen Staal M.D. 31. Date filed (Month, Day, Year) 2. Registrar's Signature State 4 2005 Registrar

		-	For State Registrar	State of Maryland / De	partment of Health and ertificate of Death	Mental Hygien Reg. N	
	Physicia		1. Decedent's Name (First, Middle, La Robert Whitaker				ay Year 3 Time of Death 8
	/Medic Examin		4a. Facility Name (If not institution, gi	ve street and number)	4b. City, Town, or Location of Dear	th 4	c. County of Death
	Funeral Director		5. Social Security Number 6. 577-20-0531	Sex 7. Age (In yrs. last birthd	Months   Days   Hours   Min		
	Aaryland show ed at	or	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town o			10d. Inside City Limits 1 ☐ Yes 2 🔀 No
	with the need or 28e-	Funeral Director	Maryland   Montgo 10e. Street and Number 314 Northwest Di		10f. Zip Code 20901	10g. C	itizen of What Country?
20	iii. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland arment of Health and Mental Hygiene. irrent: If time 27 is marked other than "naturel", or items 23e or 28e-f show injury or either treumetic event, the Medical Examiner must be notified at the contract of the contract or contr	by Funera	11. Marital Status  1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced		Was Decedent of Hispanic Origin? (:     If Yes, specify Cuban, Mexican, Puer     1 ☐ Yes 2 ☑ No Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
0500-61717	within 72 hou ene. than "nature he Mudicul E	Completed	15. Decedent's t (Specify only highest g Elementary/Secondary (0-12)	Education rade completed) 16a. Dr. (College (1-4or 5+)	ecedent's Usual Occupation live kind of work done during most of wo e. DO NOT use retired) L Estate Appraiser	orking	Kind of Business/Industry  Real Estate
Maryiand z	12 should be filled within h and Mental Hygiene. 7 is marked other than " Ireumetic event, tha Mer.	To Be Co	17. Father's Name (First, Middle, Las	t)	18. Mother's Na	me (First, Middle, Maide Whitaker	
-pom	alth and Malth a	-	19a. Informant's Name/Relationship Wilson S. Kidwel	(Type, Print) 19b. N	ailing Address (Street and Number or F 01 Shady Grove Roa	dural Route Number, City	le, Maryland 20850
altimore,	permit. Pages 1 and 2 Department of Health Importent: If Item 27 I any injury of either tre once.		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 1 ☐ Donation 5 ☐ Other (Spec	□ Removal from State 20b. Place of D  cemetery,  Metropo	sposition (Name of crematory or other place) Litan Crematory	ch 14,	Location - City or Town, State
	permit. Departiumport any inj		21. Signature of Funeral Service Lic	Geller	22. Name and Address of Facility Francis J. Collins 500 University Blv	d.,W.,Silve	r Spring,MD 20901
	nysician /Medical		23a. Part1. Enter the disease, or co shock, or heart failure. List onl tmmediate Cause (Final disease or condition resulting in death)	a. Aspiration Pneum	onia	ac or respiratory arrest,	Approximate Interval Between Onset and Death
	Examiner	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	b. Chronic Obstruct  Tue to (or as a consequence of)	ive Pulmonary Dise	ase	
8/60,	cate be executed obly sician and the burial-transit	dical Examin	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Congestive Heart Due to (or as a consequence of) Diabetes Mellitu			
.O. Box 68	e death certific the attending p ned for use as	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
1	uires that th signed by I id be detach	by	Part II. Other significant conditions	contributing to death but not resulting in t	ne underlying cause given in Part I.		o use contribute to the cause of death?  2 No 3 Probably 4 Unknown
Records,	The law requirate has been spage 2 should	Completed				24a. Was an autopsy performed?	
n of Vital	Physicien: this certific ral director,	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☒ No  27. Manner of Death 1 ☒ Natural 5 ☐ Pending	Hospital: 1 ☑ Inpatient 2 □ ER/Outp  28a. Date of Injury (Month, Day Year)  28b. Tir	atient 3 DOA Other: 4 Nursing	eath (Check only one)  Home 5 Residence  28d. Describe how in	
Division of	or At offer of Direct in by	Certification:	2 Accident investigat 3 Suicide 6 Could not 4 Homicide determine	be 28e Place of Injuny . At home farm	M 1 ☐ Yes 2 ☐ No a, street, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
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	within To th	W	29b. Signature and title of certifier	Doubles 1	29c. License number D 18813		Oate signed (Month, Day, Year)  ch 11 2005
Ý	, X (	ate	30. Name and address of person what Ira Tauber, M.D. 31. Date filed (Month, Day, Year)	o completed cause of death (Item 23a) (T  10301 Georgia A  39 Registrar's Signature	<sub>ype, Print)</sub> venue #304 Silver	Spring,Mar	y1and 20902

		1	For	partment of Health and Nertificate of Death	Mental Hygiene Reg. No.	005 10479
			Decedent's Name (First, Middle, Last)		2. Date of Death Month Day	3. Time of Death
	Physicia /Medic		Birchell Thomas Kinslow		MARCH 12	2005 2:15 A M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		County of Death
			Calvert Manor	Rising Sun  NI If Under 1 Year   If Under 24 Hrs.	Q Date of Birth	9. Birthplace (State or Foreign
	Funeral		5. Social Security Number 6. Sex 7. Age ( <i>In yrs. last birthda</i>	Months Days Hours Min.	8. Date of Birth (Month, Day, Year) eptember	1919 MD
	Director	L	723-14-5066 ST		¢poember :	. 3 / 1313 112
-	land ow	-	10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
	Mary	į	MD Cecil Risin	g Sun		1 Tyes 2 Alo
3	n the	Director	10e. Street and Number	10f. Zip Code		zen of What Country?
	23e c		1881 Telegraph Road	21911		5 • A •  4. Race - American Indian,
	tems	Funeral	Armed Forces?	<ol><li>Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puero</li></ol>		Black, White, etc.
36	hours after deeth with the Maryland turai', or items 23e or 28e-f show al Ezanirer must be mutified at	by Fi	1127 Never Married 2 ☐ Married 1 ☐ Yes 227 No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify: Black
<b>Ş</b>	tural		15 Decedest's Education 16a De	cedent's Usual Occupation	16b. Kir	nd of Business/Industry
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<u>   </u>	should be nd Mental marked o	ပ္	Unknown	Unkn ailing Address (Street and Number or Ru		Town State Zin Code)
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e)	f and Healt em 2	1 9	20a Mathod of Disposition 20b. Place of Di	sposition (Name of	Date 20c. Lo	cation - City or Town, State
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altimore,	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked any injury or other traumatic evonce.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility	13	
Ba	Dep imp any		Elward Melleown	Andrew G. Gee F		
			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arrest.	Interval Between
	Pnysician	2 0		ENTIA		Onset and Death
	/Medical		resulting in death)  a. Due to (or as a consequence of)			
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Вох	eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	3 ☐ Ectopic pregnancy		23d. Date of delivery  Month Day Year
. B	the att	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	5 Other (specify)		
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360	e las	mp			autopsy performed?	prior to completion of cause of death?
a	len: The L rtificate ha	e Co	25. Was case referred to medical	26 Place of De	1 ☐ Yes 2 No ath Check on one	1 ☐ Yes 2 ☐ No
of Vital Record	Physicien: this certific ral director,	o B	examiner?  1   Yes   22   No	Other	Home 5 Residence	6 ☐Other (Specify)
		L.	27. Manner of Death 28a. Date of Injury (Month, Day Year) Injury		28d. Describe how inju	ry occurred
io	Attending F death. ctor: After y the funer	atlo	2 Accident investigation	M 1 Yes 2 No		
Division	iei or Attendii s after death. el Director: A ed in by the fu	Certification:	3 ☐ Suicide 4 ☐ Homicide  3 ☐ Suicide 4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide	n, street, factory, office	28f. Location (Street ar City or Town, State	nd Number or Rural Route Number, a)
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	F 3 F 8		1 Kalo VA	H58419	MAR	LCH 14, 2005
•	6		30 Name and address of person who completed cause of death (Item 23a) (T	ype, Print)		
	り		KODWEY DOWNAM, D.O. 1881 TO	LEGNAPH KOND, KISING	( 27) MD 3	1911
		tate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	YPB, Print) LEGMAPH ROAD, RISING		
	Regis	trar	MAR 1 5 2005			

		1 - For Amend Ite Registrar	ems 25,27	Maryland / Dep. 28a f per Mi	rtment of 1 1,6841 03 rtificate of t	Pathand Death		jiene eg. No.	5 10480
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/Medic				H RUSSELL LE			mare		005 33:48
Examin	er	4a. Facility Name (If not institution,	-			Location of Death	1	4c. County	
		Washington Cou		.T&I 7. Age (In yrs. last birthday)	If Under 1 Year	stown If Under 24 Hrs.	O Date of Birth		shington
Funeral Director		213-40-4606 Usual Residence of Decedent	<b>1X</b> M 2□F	65 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day October	γ <sub>θα</sub> 939 28,	9. Birthplace (State or Fore Country) Maryland
land W		10a. State 10b. County		10c. City, Town or Lo	cation				10d, Inside City Lim
Mary f sh	ō	Maryland Washir	aton		Smithsbur	.~			1 <b>X</b> Yes 2 □ 1
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hour turai		15. Decedent's			dent's Usual Occupa	ation		16h Kind of B	
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and 2 Balth a n 27 is		Evelyn M. Pryor	(Mother	54 W.	Henriett	a St. Sm	ithsburg	. Marul	and 21783
s 1 and 2 f Health item 27 i	Î	20a. Method of Disposition		20b. Place of Dispo	sition (Name of	-1	Date		City or Town, State
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ortan		21. Signature of Funeral Service L			. Name and Addres	4			ourg, Maryland eral Home
permit. Pages 1 a Department of He Important: if item any injury or othe		1-100 /				,			Maryland 21783
		23a Partt. Enter the disease, or o		used the death. Do not ent					Approximate
hysician /Medical		shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)	nly one cause on ea	Shaw He	matio	n			Interval Between Onset and Death
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ne death certific the attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1□Live bir	nt at time of death 5	Ectopic pregnancy Other (specify)	V		23d. Dat Mor	e of delivery nth Day Year
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certifical	Be	25. Was case referred to medical examiner?				26. Place of Dear	th Check on on	9	
Physicien: this certific ral director,	2	1. <b>X</b> Yes <del>2. ★</del> Ho		patient 2 ER/Outpatien		4   Nursing H	ome 5 Reside	nce 6 Othe	er (Specify)
	on:	27. Manner of Death  T ☑ Hatural 5 ☐ Pending	28a. Date of (Month	Injury 28b. Time of Day Year) Injury	28c. Injury Work	at ?	28d. Describe ho	w injury occurr	ed
Attending r death. ector: After by the fune	catl	2 XAccident investiga	tion March	1,2005 Unknow	<b>vn</b> <sup>M</sup> ¹□Y	es 2X No	Subject	fel1	
in Digital	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	289. Place 0	of Injury - At home, farm, str g, etc. (Specify) At hor			— City or Town	State)	er or Rural Route Number, St., Smithbur
Hospital	edical Ce	29a. Certifier 1 Certifying (Check only one) 2 Medical E	xaminer: On the bas	pest of my knowledge, death sis of examination and/or inv	occurred at the tim	e, date and place, inion, death occur	and due to the ca	use(s) and ma	nner as stated
o the vithin 2 o the comple	Me	29b. Signature and the of pertifier	and manne		29c. License	number	29	d. Date signed	1 (Month, Day, Year)
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		20 Name and address of	be completed	1	Distrib	7575	0	5 -	2-02
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			Please		nt in Black In			•	•	ble.
			1 - For State Registrar	State of M	aryland / Depa	artment of F rtificate of I		•	giene Reg. No. 0	5 10481
	Physici /Medic		1. Decedent's Name (First, Middle, Last Louise L.	Layfi	eld			2. Date of De Month March	Day 13, 20	3. Time of Death 905 5:55P M
	Examin Funeral		4a. Facility Name (If not institution, given Salisbury Rehab 5. Social Security Number 6. S	& Nursing	Center (In yrs. last birthday)	Salisbu If Under 1 Year		8. Date of Bir (Month, Da	th	omi.co 9. Birthplace (State or Foreign
	Director		Usual Residence of Decedent	□м 2ХОГ	92 Yrs.	Months Days	Hours Min.	January	19, 1913	Salisbury, Maryla
	Marylan a-f show	ctor	10a. State 10b. County  Maryland Wicomic	20	10c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 No
	h with the 23a or 28 In Lee not	al Director	10e. Street and Number 1514 Riverside Di	cive, Apt.	C-112	10f. Zip Code 218	801		10g. Citizen of USA	What Country?
036	72 hours after death with the Maryland Insturel', or Itema 23s or 28s-f show dical Examinar munitie notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 X If Yes, Give Year or Dates:	No	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 XNo	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	o- 14. Rac Bla Specif	e - American Indian, ck, White, etc. White
Maryland 21215-0036	should be filed within 72 hours after death with the Marylan of Mental Hygiene. marked other than "naturel", or Itema 23a or 28a-f show marked other than "naturel", or Itema 23a or 28a-f show matte event, the Medical Examinar must be notilised at	Completed by	15. Decedent's Et (Specify only highest grade) Elementary/Secondary (0-12)		(Give life.	dent's Usual Occup kind of work done DO NOT use retired	during most of worl	king		usiness/Industry
and	otal Hygental Hygent,	Be	17. Father's Name (First, Middle, Last,				18. Mother's Nam	_	, Maiden Sumar	ne)
ary	2 should and Men Is marke surnatic	T <sub>0</sub>	William H.  19a. Informant's Name/Relationship (		ngston 19b. Maili	ng Address (Street	Mary and Number or Ru	Ann rai Route Numb	Ennis er, City or Town,	
Baltimore, M	ss 1 and of Heelth item 27 other tr		William F. Layfi  20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specification of the content of the conte	Removal from State	20b. Place of Dispo cemetery, cre	North Par osition (Name of matory or other place lemorial Par	ce)	Salisbu Date 18,2005	2°c. Location	yland 21804 City or Town, State
Balti	permit. Page Department of Important: if any injury or once.		21. Signature of Funeral Service Lice 23a. Part1. Enter the disease, or com shock, or heart failure. List only	cliney plications that cause	d the death. Do not en	501 Snow	Funeral Hill Roa	d, Sali	sbury, M	nal Association Maryland 21804 Approximate Interval Between Onset and Death
	Prrysician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as	a consequence of):					>24 cons
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Cisease of hips) that initiated events	Due to (or as	a consequence of):					
68760,	icate be executed physician and s the burial-translt		resulting in death) Last	Due to (or as	a consequence of):					
P.O. Box 6	Attending Physician: The law requires that the death certificate be rideath.  sctor: After this certificate has been signed by the attending physicial by the funeral director, page 2 should be detached for use as the bur	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 meriths? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death 3	⊒Ectopic pregnancy ⊒ Other ( <i>specify</i> ) _	y			ite of delivery onth Day Year
ds, P	uires that signed b	δ	Part II. Other significant conditions of		out not resulting in the c	underlying cause giv	ven in Part I.		tobacco use con Yes 2 □ No	tribute to the cause of death?
Recor	The law requite has been bage 2 shou	Completed	COPD					24a. Was auto perfe	ormed?	Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
Vita	siclan: certifica rector,	Be	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpati	ent 2 ☐ ER/Outpatie	of post of	26. Place of Dea			- (0 - 1)
Division of Vital Records,	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification: To	27. Manner of Death  1 Matural 5 Pending investigation 2 Accident investigation 3 Suicide 6 Could not be determined	28a. Date of Inj (Month, Da		of 28c. Injur Wor M 1	y at ry at rk? Yes 2 □No	28d. Describe	idence 6 □Oth how injury occur  (Street and Numi	
<u>&gt;</u>	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		4   Homicide	building, e	tc. (Specify)	-	me, date and place		wn, State)	anner as stated
	in 24 h in 24 h the Fur	ledical	(Check only 2 Medical Examone)	miner: On the basis of and manner s	of examination and/or in	nvestigation, in my o	ppinion, death occu	rred at the time	, date and place,	and due to the cause(s)
	5 m 5 m 5 m 5 m 5 m 5 m 5 m 5 m 5 m 5 m	Σ	29b. Signature and title of certifier				061688		03	d (Month, Day, Year)
	5		30. Name and address of person who	completed cause of	death (Item 23a) (Type DDDDCUT rar's Signature	Print) Druve	Chester	MD :	21619	
	St: Regist		31. Date filed (Month, Day, Year) MAR 16	2005 32. Figist	rar's Signature	hark)				

		1 - For Stete Registrar	State of Maryla		artment of H			giene /	005	10482
		Decedent's Name (First, Middle	, Last)				2. Date of De		V	3. Time of Death
Physic	cian	Shirley	Sigrist		Lewis		Month March 8	Day 200	Year 5	11:55 P <sup>M</sup>
/Mec		4a. Facility Name (If not institution			4b. City, Town, or	Location of Deat			unty of Death	1 11133 1
Exam	iner							Som	erset	
		7711 Hayward Ro		s. last birthday)	Pocomoko If Under 1 Year	If Under 24 Hrs	8. Date of Birt	h	9. Birth	place (State or Foreign
Funera			1□M 2MF	Yrs.	Months Days	Hours Min.		y, Year)	Mary	ntry)
Directo	r	218-58-0409 Usual Residence of Decedent	60				01-0/-1	945	rialy	Lanu
pu s		10a. State 10b. County	10c. (	City, Town or Lo	ocation					10d. Inside City Limits
arylis sho	=									1 ☐Yes 2XNo
If IQ X IX 13-0030 be filed within 72 hours after death with the Maryland tal Hygiene. Id other then "natural", or Items 23a or 28a-f show event, the Medical Exprinter must be notified at	Director	MD Somer	set Po	ocomoke			· · ·	10a Citizos	of What Cou	ntn/2
1 th	i e	10e. Street and Number			10f. Zip Code			•		nuy:
11 w	a	7711 Hayward Ro	oad		218.				SA	
deal	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (S n. Mexican, Puer	Specify Yes or No to Rican, etc.)	- 14.	Race - Ameri Black, White,	
or He	E	1 Never Married 2 Mar	ried 1 □Yes 21KTNo		1 ☐ Yes 2 X No	Specify:			ecify:	
hours after tural; or Ite	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		12 163 22 100	opoony.			Wh	ite
2 ho	Completed	15. Deceden	it's Education	16a. Dece	dent's Usual Occupa	ation	rkina	16b. Kind	of Business/Ir	ndustry
within 72 ene. then "na	pie	(Specify only higher Elementary/Secondary (0-12)	st grade completed)  College (1-4or 5+)	life.	kind of work done of DO NOT use retired	)	rang			
d within 72 hours afigene. The Mauliful Exam.	E	1 2	none	Hom	emaker			Own	Home	
e filed vall Hygie I other vent, E		17. Father's Name (First, Middle,				18. Mother's Na	me (First, Middle	Maiden Su	mame)	
n 0	Be	Talan II Ciomia	<b>+</b>			Minnie	Dashiell			
should be nd Mental marked c	2	John W. Sigris  19a. Informant's Name/Relations		19h Mail	ing Address (Street a				own, State, Zi	p Code)
Maryland d 2 should be file th and Mental Hy ty Is marked oth traumatic event					Hayward					
		Archie Lewis,					Date		tion - City or T	
of H		20a. Method of Disposition  1 ■ Burial 2 □ Cremation	3 DRemoval from State	cemetery, cre	osition (Name of matory or other place	e)	Date	200. 4002	tion - City or i	Own, State
Pages nent of nnt: If it		4 □Donation 5 □ Other (5		uinton	Cemetery_	03-	12-2005	Pocom	oke Ci	ty, MD
permit. Pages 1 ar Department of Hea Important: If item any injury or other	oi l	21 Signature of Funera Service		2	2. Name and Addres					
Deg de de de de de de de de de de de de de	8	( amou) I HI	MMQUO A) MOO.	205 H	inman Fun 1673 Some	eral Hom	le Prina	Acc A	nne M	D 21853
Pnysicia /Medica Examine	al	27a. Part1. Enter the disease, o shock, or heart failure. Lis mmediate Cause (Final disease or condition resulting in death)	r complications that caused the detenty one cause on each line.  a  Due to (or as a cons	LUNG	_		ic or respiratory a	rrest,		Approximate Interval Between Onset and Death
8 / bU, cate be executed bysician and the burial-transit	dical Examiner		b. Due to (or as a cons c. Due to (or as a cons d							
Hecords, F.O. Box of The law requires that the death certifica tie has been signed by the attending ph page 2 should be detached for use as the	Physician/Med	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No  9 □ Unknown	23c. If yes, outcome of pre 1   Live birth 2   F 4   Pregnant at time of 9   Unknown	etal death 3	□Ectopic pregnancy □ Other (specify) _	,		23	d. Date of deli Month	very Day Year
dS, P. uires that t i signed by id be detail	_   ≥	Tall III Still Significant	ions contributing to death but not	resulting in the	underlying cause giv	en in Part I.	λ.	yes 2 🗆		the cause of death?
VITAL RECONDISCION SICIAN: The law requires certificate has been si irector, page 2 should I	Completed	to-	0 10000				24a. Was	an	24b. Were au	topsy findings available completion of cause of
fec e taw has ye 2 t	d d	lean	Le juines				auto	psy ormed?	prior to death?	
	Ö		· · · · · · · · · · · · · · · · · · ·				1 ☐ Yes	2 No	1 🗆 Yes	2 No
r VITAL HC ysician: The is certificate ha	Be	25. Was case referred to medic	al				eath Check on	one	_	
. > 0) 73	2		Hospital: 1 ☐ Inpatient 2	2 C ER/Outpatie	ent 3 DOA	er: 4 Nursing	Home Kes	idence 6 !	☐Other (Spec	city)
on O' ling Ph After th Tuneral	ilon:		28a. Date of Injury ing (Month, Day Year tigation	r) 28b. Time Injury	Wor	yat rk? Yes 2 ∐No	28d. Describe	how injury	occurred	
Division al or Attending s after death. Il Director: Atte	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	a not be mined 28e. Place of Injury - A building, etc. (Sp.		treet, factory, office		28f. Location City or To	(Street and wn, State)	Number or Ru	ral Route Number,
DIVISIC  To the Hospital or Attend within 24 hours after death To the Funeral Director:: completely filled in by the I	edical (		ing Physicien: To the best of my I Examiner: On the basis of exam and manner stated.	knowledge, dea nination and/or	investigation, in my o	opinion, death oc	ce, and due to the curred at the time	, date and p	lace, and due	to the cause(s)
To the comp	Σ	29b. Signature and title of certif	91/		29c. Licens			29d. Date	signed (Month	n, Day, Year)
->=0		put 1	a pull		D36	576		3/1	0/05	
		an Name and address of passa	n who completed cause of death (	(Item 23a) (Type	a. Print)			<u>-</u>		
		Parent	P. TRAVITZ	- MC	560	Ruers	ide à	PAKE	BURY	MD 21801
	State istrar	IVIAH	32. Redistrar's S	· K	book					

			_ For	riease	State of Ma				t. Ensure A Health and N				10483
			1 - State Registrar				Cei	rtificate of	Death		Reg. No.	-000	10400
	Physici	an	Decedent's Name     A NOT							2. Date of Dea	Day		3. Time of Death
ng.	/Medic				ARY MEEH street and number)	IAN		4b. City, Town,	or Location of Death	MARCH (		2005 County of Deat	11:10 P M
	LXAIIII	CI		•	CAL CENTER	{		CAMP SPR		YLAND		INCE GE	
B).	Funeral		5, Social Security No	11	7. Age		st birthday) Yrs.	If Under 1 Yea Months Days	If Under 24 Hrs.	8. Date of Birt (Month, Da	h		hplace (State or Foreign untry)
24	Director		579-32-89 Usuel Residence of	15		79	113.			DEC. 5	, 192	25 WAS	HINGTON, DC
	how		10a. State	10b. County		10c. City,	Town or Lo	ocation					10d. Inside City Limits
	Ba-f s	Director	MD	PRINCE (	GEORGE	OXC	N HIL						1 ☐ Yes 2 🙀 No
:	n 72 hours after death with the Maryland "neturel", or Items 23a or 28a-f show suitel Exentiner clust be notified at		10e. Street and Nun		) A CIE			10f. Zip Code				zen of What Co	untry?
	death ms 23	Funerai	11. Marital Status	EAVER TER	12. Was Decedent I	Ever in U.S	5. 13.	20745 Was Decedent of	Hispanic Origin? (S) ban, Mexican, Puerto	pecify Yes or No		J.S.A. 4. Race - Ame	
و	or Ite			ed 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give X	No		If Yes, specify Cu 1 ☐ Yes 2 <b>X</b> ☐ No		o Rican, etc.)		Black, White	
2-003p	hours ural',	d by	3X Widowed		Year or Dates:							Specify: WH	
ָלָרַאַ בּרָאַ	d within 72 ho piene. r then "netur the Wedleal	Completed		15. Decedent's Ed ify only highest grad	de completed)		(Give	dent's Usual Occu kind of work done DO NOT use retir	ipation a during most of wor ad)	king	16b. Kir	nd of Business/	Industry
717	filed within thygiene.  Hygiene.  ther then "i	Com	Elementary/Second 12	ndary (0-12)	College (1-4or 5	)+)	HOME	MAKER			OV	N HOME	
2	0 = 0 5	Be	17. Father's Name (						18. Mother's Nam			Sumame)	
Maryland	should b ind Ments i marked umatic e	၉		COPPOLA	voe Print)		19h Mailie	na Address /Stree	FLOREN	CE FASUI		Tour State	Zin Code)
	ss 1 and 2 should of Health and Me Item 27 is mark r other traumatik				N - DAUGHT	ER			TERRACE,				
w .	as 1 a of Hea Item rothe		20a. Method of Disp		2	20b. Pla		sition (Name of matory or other pl		Date		cation - City or	Town, Stete
Ĕ	Peg ment tant: it		* 4 □Donation	5 Other (Specify	Removal from State	1			L CEM. 4/	4/05	ARI	LINGTON	, VIRGINIA
Baltimore,	permit. Peges Department of t Important: If its eny injury or of once.		21. Signature of Fu	neral Service Licent	988			2. Name and Addi	. р	EMAINE 1			Ε
			23a. Part1. Enter th	ne disease, or comp	cations that caused one cause on each lin	the death.			SHINGTON ing, such as cardiac			RIA, VA	22314 Approximate
	Physician		Immediate Cause (	Final		10.			-				Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	(	a. SEPSTS  Due to (or as	a conseque	ence of):						09 HOURS
2.	Examiner	_	Sequentially list cor	nditions,	b PNEUMONI								24 HOURS
	ned ned	Examiner	Sequentially list cor if any, leading to im cause. Enter Unde Cause (Disease or	rtying injury	Due to (or as	a conseque	ence or):						
o	be executed icien and burial-transit		that initiated events resulting in death) L		Due to (or as	a conseque	ence of);						
		Physician/Medical		(	d								
x 68	death certificate e attending phys id for use as the	/Med	IF FEMALE:		23c If yee outcome	of pregnan							
Вох	attene attene	cian	23b. Was decedent in the past 12	months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetel	death 3	Ectopic pregnant	су		2	3d. Date of deli Month	ivery Day Year
<u>о</u>	by the de	hysi	1 □ Yes 2 v 9 □ Unknown	ZINO	9□ Unknown								
	s th	þ			ontributing to death b	ut not resul	lting in the u	nderlying cause g	iven in Part I.				the cause of death?
ord ord	A require been sig should b	eted	RENAL FAI	LURE						1 1	/es 2[	No 3□Pr	obably 4 Unknown
ec E	The law ste has b bage 2 s	Completed								24a. Was autop		24b. Were au prior to death?	topsy findings available completion of cause of
e	inficete or, pa		25. Was case refer	red to medical					26 Place of Dec	1 ☐ Yes	2√ No	1 ☐ Yes	2 No
5	nysician: The law nis certificete has l director, page 2 s	To Be	examiner?		Hospital: 1 XInpatie	ent 2 🗆 E	R/Outpatier	nt 3 DOA	26. Place of Dea ther: 4 \(\sum \) Nursing H	ome 5 Resid		Other (Spec	cify)
Division of Vital Records,	ng Pi		27. Manner of Deatl	h 5 🗆 Pending	28a. Date of Inju- (Month, Day	ry y Year)	28b. Time o Injury	W	ury at ork?	28d. Describe h			
<u>sio</u>	ottendi death. ctor: A y the fu	icati	2 Accident 3 Suicide	investigation 6 Could not be		un. At hor	no form str	M 1 [	]Yes 2□No	20f Location /6	Yeart and	(Alumbas as D	and Boute Manhar
o≤	or Attend after death Director: d in by the	Certification:	4 🗀 Homicide	determined	building, etc	c. (Specify)	ne, iaim, sti	төөт, тастогу, опісе		City or Tow			ral Route Number,
	Hospital     24 hours a     Funeral ( letely filled		29a. Certifier (Check only	1 Certifying Physical Even	ysician: To the best	of my know	viedge, deati	h occurred at the	time, date and place	and due to the	cause(s)	and manner as	stated.
	To the Hos within 24 h To the Fur completely	Medical	Uner)		iner: On the basis of and manner sta	ated.	on and/or in						
	T will	~	29b. Signature and	title of certifier					ise number		29d. Date	signed (Month	n, Day, Year)
	(1)		30. Name and address	ess of person who	completed cause of d		23a) (Type		071370-	- M	ARCH	10, 20	05
- (	18/				MD 1050 WE			,	NDREWS AF	B, MD 20	0762		
	Sta	ite	31. Date filed (Mon.	th, Day, Year)	2. Registra	ar's Signati							

			1 - For Registrar	State of Mar	•	artment o		•	giene Reg. Np.	
			Decedent's Name (First, Middle, Last,	)				2. Date of De	ath CUU	3. Time of Depth
	Physici		MICHAEL	E. N	ONTGOMERY	,		MARCH	7,2005 <sup>ear</sup>	4:42P. M
	/Medio Examin		4a. Facility Name (If not institution, give		.01,200.422.		n, or Location of Deal	th	4c. County of Dea	th
1			1907 BENDER COURT			LANDOV	/ER		PRINCE GE	PODCES
	Funeral		Social Security Number     6. Security Number		'In yrs. last birthday)	If Under 1 Ye	ar If Under 24 Hrs			thplace (State or Foreign
	Director		213-21 <b>-</b> 9959	M 2□F 2	29 Yrs.	WOTUTS Da	ys Hours will	March	16, 1975	Wash., DC
	pur *		Usual Residence of Decedent  10a. State 10b. County	1	Oc. City, Town or Lo	oation				and Inside Obstitution
	show	5			oo. Oily, rown or Lo					10d. Inside City Limits 1X Yes 2 □ No
	28a-f	Director	Md. Prince G	eorge's			inton		40.000	
	with B or	늅	10505 Thrift Ro			10f. Zip Cod	20735		10g. Citizen of What Co	
	eath	Funeral	10303 INFILL RO	12. Was Decedent Ev	erin IIS 13 1	Was Decedent		Specify Ves or No	United S	
4.0	ter d	Ę	1 ☑ Never Married 2 ☐ Married	Amed Forces? 1 ☐ Yes 2 🔀 No	13.	If Yes, specify C	of Hispanic Origin? (S Juban, Mexican, Puer	to Rican, etc.)	Black, Whit	
936	urs al	5	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🔼 i	No Specify:		Specify:	Black
21215-0036	filed within 72 hours after death with the Maryland Hygiene. thar than "natural", or itams 23a or 28a-1 show thar than "natural", or itams 12a or 28a-1 show ant, the Medical Exar & werrings be profiled at	Completed	15. Decedent's Edu	cation	16a. Deced	dent's Usual Oc	cupation		16b. Kind of Business	/Industry
2	thin 7	pie	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	life	DO NOT use re	ne during most of wo tired)	rking		
2	ad will	Son	12th			Cook			Restaurant	
nd	d oth	Be (	17. Father's Name (First, Middle, Last)						Maiden Sumame)	
yla	Meni Meni arka	ဥ	Albert Montgome	ery					Carrol1	
Maryland	s 1 and 2 should be filed within 72 hours after death with the Maryla if Health and Mental Hygiene. Itam 27 is marked other then "natural", or itams 23e or 28e-1 show other traumatic event, the Medical Exert and crimit be multipled at		19a. Informant's Name/Relationship (Ty						er, City or Town, State, .	Zip Code)
	1 and 2 Health tam 27 l		Albert Montgomery  20a. Method of Disposition	/ rather	20b. Place of Dispo		Road C1	Date Date		T 01-1-
Baltimore,	Pages nent of h ant: If Its ury or of		12 Burial 2 ☐ Cremation 3 ☐ F	lemoval from State	cemetery, crer	natory or other	place)		20c. Location - City or	
Ë	t. Page rtment rtant: It		* 4 □ Donation 5 □ Other (Specify)	0 1	Ghenwood					ton, D.C.
Bal	permit. Pages 1 and in Department of Health Important: If Itam 27 any injury or othar traging.		21. Signature of Funeral Service Licens	Kron	Jally	1425 Ma	aryland Av	e., NE	Mortuary, Wash., DC	Inc. 20002
			23a. Part1. Enter the disease or complete shock, or heart failure. List only or	ications that caused the cause on each line.	ne death. Do not ent	er the mode of	dying, such as cardia	c or respiratory a	rrest,	Approximate interval Between
	Physician		Immediate Cause (Final disease or condition	Mul	iple que	ushot	wounds	3		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	- //					
	LAGITITIES	_	Sequentially list conditions,	o						
	ed sit	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a o	consequence of):					
	and and II-tran	xan	that initiated events resulting in death) Last	Due to (or as a	consequence of):					
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and cage 2 should be detached for use as the burial-transit	dicai Examiner			,					
687	licate phys s the			d						
Box (	death certifica attending pt d for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of	pregnancy				23d. Date of de	iver
ğ	death atte	ciai	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at tir		Ectopic pregna Other (specify			Month	Day Year
P.O.	that the death cer ed by the attendin detached for use	hysi	9 Unknown	9□ Unknown						
	es that igned t be det	by P	Part II. Other significant conditions co	ntributing to death but	not resulting in the u	ndertying cause	given in Part I.	23e. Did t	obacco use contribute to	the cause of death?
Records,	w requires been sign should be	pa pa						1 🗆 '	Yes 2 XNo 3 ☐ Pi	robably 4 Unknown
S	law requas been 2 should	ojet						24a. Was		utopsy findings available
Re	The law	Completed							osy prior to death?	completion of cause of
Vital		a)	25. Was case referred to medical	<u>-</u>			26. Place of De	ath (Check only o	2 No Yes	2 No
<u>&gt;</u>		To B	examiner? 1 X Yes 2 □ No	lospital:	2 ER/Outpatien	nt 3□ DOA	Othor		dence 6 XOther (Spe	city) SCENE
J of	ding Phys	L.	27. Manner of Death	28a. Date of Injury (Month, Day )	28b. Time of		njury at Work?		now injury occurred	
Ö	Attending ir death. ector: After by the fune	atio	1 □ Natural 5 □ Pending 2 □ Accident investigation	3/7/05	Formul 16.		I ☐ Yes 2 🗖 No	Subje	ct short	
Division	r Atte	tific	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	- At home, farm, str		се	28f. Location (S City or Tox	Street and Number or Ri	ural Route Number,
	ital o	Certification:	/	3	Side	walk			Ler Court, Las	dover, MD
	To the Hospital or Attending Ph within 24 hours after death. To tha Funaral Director: After th completely filled in by the funeral	Medical	29a. Certifier 1 Certifying Phy (Check only one)  1 Certifying Phy 2XMedical Exami	sician: To the best of ner: On the basis of e and manner state	xamination and/or in	h occurred at the vestigation, in m	e time, date and place ny opinion, death occ	e, and due to the urred at the time,	cause(s) and manner as date and place, and due	s stated. to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier			29c. Lic	ense number		29d. Date signed (Mont	h, Day, Year)
			1 Talvill	lah Al	-	C	CME	ı	MARCH 8,200	5
0	(2)		30. Name and address of person who or 7. ABIULLA		th (Item 23a) (Type,		enn Street			
	Sta		31. Date filed (Month, Day, Year)  MAR 1 4 2005	3 Registrar	s Signature		CILI DELCE	- патен	more, Maryl	and ZIZOI
	Regist	al	MAR 1 4 200.	moun	Je 149					

	-	For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	ertificate of l			giene leg. No. () (	15	10485
Physicia	an	Decedent's Name (First, Middle, Last)			MCKAY		2. Date of Dea Month MARCH	Day	Year	3. Time of Death
/Medic Examin	al	MARGARET VAN  4a. Facility Name (If not institution, give s	DER street and number)	LINDEN		Location of Death	MHKCH	4c. County	of Death	10,70
Funeral Director	eı	The Johns Hopks 5. Social Security Number 6. Sex	ins Hos	O, LA L e (In yrs. last birthda) Yrs.	100	If Under 24 Hrs. Hours Min.	8 Date of Birth (Month, Day July 14	r, Year)	Coun	lace (State or Foreign try) ngton, D. C.
D		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or I	ocation		Dary II	, 2, 3, 5		0d. Inside City Limits
Maryla f ehov	5			Co1u						1 ☐ Yes 2 ☑ No
r 28e-	Director	Maryland Howard  10e. Street and Number		COLU	10f. Zip Code			10g. Citizen of	What Coun	itry?
ath wit	ralD	10056 Cape Ann Dri			21046			USA		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural; or items 23s or 28e-f ehow any injury or other traumatic event. It a Modical Examination to interest and the page.	by Funeral	11. Marital Status  1 □ Never Married 2 ★ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ I If Yes, Give Year or Dates:		. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2½ No	Ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)		ce - Americ ck, White, fy: Whit	etc.
72 hou	eted	15. Decedent's Edu (Specify only highest grade	cation e completed)	(Giv	edent's Usual Occup	during most of work	king	16b. Kind of B		
within ne.	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+) life.	DO NOT use retired	1)		Donart	mont	of Defense
filed v Hygie other t	Be Co	17. Father's Name (First, Middle, Last)	4	Ana	lyst	18. Mother's Nam	e (First, Middle,			or perense
Mental Mental rrked ritic ev	To B	Frank M. van der	Linden			Georgi	a K. Hu	dd1e		
2 sho and ! is me		19a. Informant's Name/Relationship (Ty	rpe, Print)	19b. Ma	iling Address (Street					Code)
1 and Health em 27 ther t		Ryan P. McKay  20a. Method of Disposition	Husbar	20b. Place of Dis	6 Cape Ani position (Name of	1	Columbi.	a Mary 20c. Location		21046 own, State
A si E E		1 XBurial 2 ☐ Cremation 3 ☐ P  4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	Greenlaw	n Memorial Park		4 2005 1	Jilliam	cnort	.Maryland
permit. F Depertme Importar any injur		21. Signature of uneral Service Licens	elle	F	rank 22. Name and Addres rancis J. 00 Univers	ss of Facility Collins	Funera1	Home,	Inc.	**************************************
Pnysician	(0)	23a. Part1. Enter the disease, or compl shock, or heart failure. List only of Immediate Cause (Final disease or condition	ications that caused ne cause on each li	d the death. Do not e ne.	nter the mode of dyin	ig, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death 24 Hours
/Medical Examiner		resulting in death)	Due to (or as	a consequence of):	unity-Acc	sec > 4	).[6., 4.54	e oA		4 D.
	Jer	Sequentially list conditions, if any, leading to immediate	0	a consequence of):	unity - rec	amken i	NEWHON	1 174		4 vays
requires that the death certificate be executed een signed by the attending physician and hould be detached for use es the burial-transit	ai Examiner	cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence of):						
tificate ng phys es the	edicai		d					7/1		
he death certif the attending shed for use e	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant a 9□Unknown	2 Fetal death	B Ectopic pregnancy I Other (specify)	/			ate of delive onth	ery Day Year
w requires that the dobes signed by the should be detached	by	Part II. Other significant conditions co	ntributing to death b	out not resulting in the	underlying cause giv	ren in Part I.		obacco use con /es 2 \( \subseteq \text{No} \)	tribute to tl	ne cause of death? pably 4 Munknown
The law ate has b page 2 sl	Completed	ļ					24a. Was autor perfo 1  Yes		Were auto prior to co death? 1  Yes	psy findings available mpletion of cause of 2 No
c = =	Be	25. Was case referred to medical examiner?	Hospital:	2 TER/O	iont 27 DOA Oth	26. Place of Dea			h (Ca)	-
nicia certi recto	0	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpati 28a. Date of Inju (Month, Da	ury 28b. Time	of 28c. Injur	y at	ome 5 Resident Reside			у)
nding Phyaician: tth. :: After this certific e funeral director,	H-	1 Natural 5 ☐ Pending investigation					28f Location /	Street and Num	her or Rura	J Paula Mumbas
or Attending ter death, irector: After by the funer	H-			jury - At home, farm, tc. (Specify)	street, factory, office		City or Tov			ar noute Multiper,
or Attending ter death, irector: After by the funer	Certification; T	2 Accident 3 Suicide 4 Homicide  29a. Certifler (Check only one)  Chack only one)  investigation 6 Could not be determined	building, e	tc. (Specify)  of my knowledge, de of examination and/or	ath occurred at the tin investigation, in my c	ppinion, death occu	City or Tov , and due to the rred at the time,	vn, State) cause(s) and m date and place,	anner as s , and due to	tated. o the cause(s)
To the Hospitel or Attending within 24 hours efter death. To the Funeral Director: After completely filled in by the funer	H	2 Accident 3 Suicide 4 Homicide  29a. Certifler (Check only 1 Medical Exami	building, e vsician: To the best iner: On the basis of	tc. (Specify)  of my knowledge, de of examination and/or	ath occurred at the tir investigation, in my of 29c. Licens	ppinion, death occu	City or Tov , and due to the rred at the time,	cause(s) and m date and place, 29d. Date signs	nanner as s , and due to ed (Month,	tated. the cause(s)  Day, Year)
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		1 - State of Maryland		artment of artificate of		nd Me		iene	05	10486
		Decedent's Name (First, Middle, Last)				2	. Date of Deat	h	U U	3. Time of Death
Physicia /Medic		Carl A. McCollough					Month March 1	1	-	2:02 AM M
Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town,		Death			y of Death	
		7801 Spout Springs Road  5. Social Security Number 6. Sex 7. Age (In yrs. Ia	et hirthday)	Fred If Under 1 Year	derick r   If Under 24	Hrs. a	. Date of Birth	Fre	deric	
Funeral Director		474-01-4788 150 M 2 F 86	Yrs.	Months Days		Min.	(Month, Day, SEPT . 17			olece (State or Foreign htry)
		Usual Residence of Decedent					EFI. 1/	,1910	Iow	<u>a</u>
yland		10a. State 10b. County 10c. City,	Town or Lo	cation					1	10d. Inside City Limits
Mar Hed	tor	Maryland Frederick F	reder	ick						1 ☑Yes 2 ☐ No
h the	Funeral Director	10e. Street and Number		10f. Zip Code			10	0g. Citizen of	What Cour	ntry?
h wit	ai D	7801 Spout Springs Rd.		2170	02			Unite	d Sta	ates
dea	ner	11. Marital Status 12. Was Decedent Ever in U.S Armed Forces?	i. 13. V	Was Decedent of f Yes, specify Cul	Hispanic Origin	n? (Specif	fy Yes or No-		ce - Americ	
or He		1 Never Married 2 Married 1 Types 2 No		1 ☐ Yes 2√2 No		delloria	oan, otc.)	Specia		etc.
ours in it	d by	3 MWdowed 4 □ Divorced Year or Dates:							Whi	
72 1	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occu kind of work done DO NOT use retire	pation during most o	of working		16b. Kind of E	Business/In	dustry
within the n	du	Elementary/Secondary (0-12) College (1-4or 5+)		eacher	90)			D., L 1 4	- C-1-	1 C+
iled within 72 hours after death with the Maryland Hygiene. Hygiene Hygiene, then the That the Than the Han "natural", or items 23s or 28s-f ehow ent, its Madical Examiner must be mailified at		17. Father's Name (First, Middle, Last)	16	eacher	18 Mother's	Name //	First, Middle, N			nool System
- d - d - d	Be		Collou	, ch	Mar		1101, 11110010, 11	Pink		
d Me	To	19a. Informant's Name/Relationship (Type, Print)		ig Address (Stree			Route Number			Code
d 2 s d 2 s th an trau										· ·
Heali		Steven McCollough / Son  20a. Method of Disposition 20b. Pla	ace of Dispo	Sunnybi		. / P		K, Mar 20c. Location		
D ages		1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State		natory or other pla		111/				
mit. Pages partment of portant: if it y injury or o		`4 □ Donation 5 □ Other (Specify) Fred  21. Signature of Funeral Service Licensee □		Cremato:						Maryland
Dai Departiment Impo		21. Signature of Furiorial Service Licenses				Dea				es, P.A.
		23a. Part1. Epter the disease, or complications that caused the death.							Maryı	Approximate
		shock, of heart failure. List only one cause on each line.				1				Interval Between
Physician		Immediate Cause (Final disease of condition resulting in death)	ne (	Pordin	Kesul	w	Dise	ne		Onset and Death
/Medical Examiner		Immediate Cause (Final disease of condition resulting in death)  a.   Due to (or as a consequence of the con	ence of):	Cordin	Kesul	u)	Dise	ne		Onset and Death
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		State of Maryland / Department of Health and Mental Hygiene  Per FH PCC cr Certificate of Death Reg. No. 1 5 1 1 1
Physicia	м	1. Decedent's Name (First, Middle, Lest)  2. Date of Death 3: Time of De Month Day Year  Month Day Year  3. 1 0 a
/Medic Examin		4a. Fecility Name (If not institution, give street end number)  4b. City, Town, or Location of Death  4c. County of Death
Funeral Director		St. Thomas More  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  7. Age (In yrs. last birthday)  93 95 Yrs.  Hyattsville Md P.G.  Hyattsville Md P.G.  8. Date of Birth (Month, Dey, Year) 1909  9. Birthplace (State or Find Min. Min. April 28, $\frac{1}{29}$ Sumter Co
show	7.	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City L  Md. P.G. Hyattsville 11 Yes 2
with the Mary la or 28a-1sh	Director	Md. P.G. Hyattsville 106. Street and Number 107. Zip Code 109. Citizen of What Country? 4922 Lasalle Rd. 20782 U.S.A.
72 hours after death with the Maryland netural; or items 23e or 28e-1 show actal Examinet be notified at	by Funeral	11. Marital Status  12. Was Decedent Ever in U,S. Armed Forces?  1   Never Married 2   Married  3   No
d 2 should be filed within 72 hours af th and Mental Hygiene. 71 se marked other than "netural; or traumatic event, it is Medical Exercite	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  College (1-4or 5+)  College (1-4or 5+)  College (1-4or 5+)  College (1-4or 5+)  College (1-4or 5+)  College (1-4or 5+)  College (1-4or 5+)  College (1-4or 5+)  College (1-4or 5+)
uld be filed Mental Hygir rked other tic evant,	To Be Co	10th 17. Father's Name (First, Middle, Lest)  Boston Gordon  18. Mother's Name (First, Middle, Maiden Sumame)  Julia Gordon
		19a. Informant's Name/Relationship (Type, Print)  Deloris Frierson-Daughter  19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)  485 Lenox Ave, N.Y. N.Y. 10037
		20a. Method of Disposition  **DBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, cremetory or other place)  Mt. Zion Cemetery  3-12-0  Date 20c. Location - City or Town, State 3-12-0  Baltimore, Md.
permit. Pag Depertment Important: I any injury o		21. Signatur of Funeral Service Licensee  22. Name and Address of Facility  Dunn & Sons 5635 Eads St, N.E.
Physician /Medical Examiner	er	23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate Interval Between Onset and Death  Immediate Cause (Final disease or condition resulting in death)  Due to (or es e consequence of):
cate be physicia s the bur	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or inlury that imitated events resulting in death) Last  b. Due to (or es e consequence of):    Due to (or es e consequence of):
net the death certi d by the attending deteched for use a	by Physician/M	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23b. Did tobacco use contribute to the cause of death but not resulting in the underlying cause given in Part I.  1   Yes 2   No 3   Probably 4   Un
aw requires the	Completed by	24a. Was en autopsy performed?  24b. Were autopsy find evailable prior to completion of cause of death?
ysicien: The law iis certificate hes I director, pege 2 s	Ве Соп	1 ☐ Yes       2 ☐ No       1 ☐ Yes       2 ☐ No         25. Was case referred to medical       26. Plece of Death (Check only one)
	မ	examiner?    Hospital:   I patient   I pat
To the Hospital or Attending within 24 hours after death within 24 hours after death.  To the Funeral Director: After completely filled in by the fur	Medical Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number of Building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number of Town, State)
the Hospital hin 24 hours a the Funeral I npletely filled	Medical	29a. Certifler  (Check only onl)  29b. Signature and title of certifier  29c. License number  (Month, Dey, Year)
To vit	-	Bulance Ively D01852 MARCH & 2005
2		30 Name and address of person who completed cause of death (Item 23e) (Type-Print) Paul A. DeVare Mburo3 Queens buyfel Hyattsville MD 26781
Sta Registr		31. Date filed (Month, Day, Year)  ARR 1 4 2005

DHMH 16 Rev 6/95

442

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month MALMER Year SMITH NANCY 405 MARCH 2005 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SANDYSPRING BROOKEGROVE REHABILITATION AND HULSANG CENTER MONTGOMERY If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral**  Birthplace (State or Foreign Country) Days Months 1 ☐ M 2 🔀 F Hours Director 218-24-0038 76 1928 March Washington,D C Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other then "netural", or items 23a or 28e-f sho event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 No Laytonsville Md. Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 25211 Bonny Brook Lane 20882 Funeral Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 No f Yes, Give Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: ģ 3 ☐ Widowed 4 ☑ Divorced Specify. White Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. 12 4 Human Resources Manager Publication Pages 1 end 2 should be filed nent of Health and Mental Hygii int: if Item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Depertment of Health and Menta Important: If Item 27 is marked any injury or other traumatic evence. Gertrude Newlon Roger Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25211 Bonny Brook Lane, Laytonsville, Md. 20882 Russell B. Palmer / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 3/12/05 Alexandria, Va. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Muriel H. Barber Funeral Home Box 5038, Laytonsville, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) a CARCINOMA OF THE ESOPHAGUS WITH MONTHS Examiner Due to (or as a consequence of): METASTASES Examiner physician end s the burial-transit or Attending Physicien: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) P.O. Box 68760, Physiclan/Medical Due to (or as a consequence of): resulting in death) Last use as t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 ☐ Yas 2 No 3 Probably 4 Unknown Division of Vital Records, þ page 2 should be Completed Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 2 No 1 ☐ Yes 2 No 1 Tes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: Certification: To Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) efter death. Director: After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1. Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours \*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the I within 2 29b. Signature and title of cortifier 29c. License number 29d. Date signed (Month, Day, Year)

Sempleted cause of death (Item 23a) (Type, Print)

25 PMAN, M.D. 18100 SLADE SCHOOL ROAD SANDY SPRING MARYLAND

ress of person who completed cause of death (Item 23a) (Type, Print)

14 2005

RACE BROOKE HI 31. Date filed (Month, Day, Year)

State

Registrar

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		•	for State Registrar		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		rtificate				, ,	g. No.	UU5	101	÷90
			1. Decedent's Name (First, Middle, L	ast)							2. Date of Deat Month	h	Vana		of Death
	Physicia /Medic		Josephine Sau	nders	Raymond						March 1	1, Day	2005	6:40	ја м
	Examin		4a. Facility Name (If not institution, g	ive street and nu	m <i>ber</i> )		4b. City,	Town, or	Location of	of Death		4c. C	County of Dea	ath	
			4428 Independenc			a sa te independence l	Roc If Under	kvi1	1e If Under:	04 Hrs	2 Date of Birth	1	Montgo	mery	
ì.	Funeral Director			Sex 1□M 2∏gF	7. Age (In yrs. I	ast birtnday). Yrs.		Days	Hours	Min.	8. Date of Birth (Month, Day,	Year)	. 1	rthplace (State	a or Foreign
			220-07-2319 Usual Residence of Decedent		84						Oct.28,	1920	) Ma	ryland	
	how Lat		10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside	
	e Ma Ba-f	Director	Maryland Montgo	mery		Rocky									es 2 🙀 No
	be filed within 72 hours after death with the Maryland Hygiene. Hygiene do they then "natural", or items 23e or 28e-f show do other then "natural", or items 23e or 28e-f show event. It a Wadical Enarliner must be notified at	Dire	10e. Street and Number				10f. Zip	Code			1	0g. Citiz	en of What C	Country?	
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	ter de Iren	Funeral	11. Marital Status  1 ☐ Never Married 2 ☑ Married	Armed F	orces? 2[X]No	3. 13.	If Yes, spec	ify Cubar	n, Mexican	, Puerto	ecify Yes or No- Rican, etc.)	'	Black, Wh		
920	urs af	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, G Year or I	ive		1 ☐ Yes 2	!₩ No	Specify:			3	Specify: W	hite	
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7	ithin "ie.	nple	Elementary/Secondary (0-12)		1-4or 5+)	life.	DO NOT us	e retired)	)						
2	led w tygier her th		17. Father's Name (First, Middle, La.	24)		Cle	rk		19 Motho	r's Alams	(First, Middle, I		etail		
anc	be finds the finds of the finds	Be			•				TO. MOUTE				ourname)		
Ž	thould d Me mark matic	유	Joseph W. Saun  19a. Informant's Name/Relationship			19b. Mailir	na Address	(Street a	nd Numbe	Edn.	a Gra	City or	Town, State,	Zip Code)	
Z	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Healih and Mental Hygiene.  Department of Healih and Mental Hygiene.  Department of Healih and Mental Hygiene.  Department of Healih and Mental Hygiene.  Department of Hygiene traumatic event, the Medical Enanther must be recitived at once.		James E. Raymond		ısband		Indep					-		vland 2	20853
re,	thea item		20a. Method of Disposition		20b. P	lace of Dispo	sition (Nam	e of						r Town, State	_0000
Ē	Page int: If		1 🖾 Burial 2 □ Cremation 3 1 □ Donation 5 □ Other (Spec		State Fort	t Linc	oln	eter		for 1	4,2005	tron	twood	Marula	n.d
Baltimore,	mit. partn porte y Inju	İ	21. Signature of Funeral Service Lie	ense		22 E *	2. Name and	Addres	s of Facilit	V	Funeral			5	440
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П			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that y one cause on	caused the death each line.	n. Do not ent	er the mode	of dying	g, such as	cardiac o	r respiratory arr	est,		Approxim Interval B Onset an	Between
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Вох	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	itcome of pregna birth 2 ☐ Fetal	death 3	Ectopic pre					23	3d. Date of de Month	elivery Day	Year
o.	the a	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Preg 9□ Unki	nant at time of de nown	eath 5	Other (spe	əcify)							
۵.	that the by detact	/Ph	Part II. Other significant conditions	contributing to	death but not resu	ulting in the u	nderlying ca	ause give	n in Part I.		23e. Did tol	acco us	e contribute	to the cause o	f death?
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CO	s been si	olete	Alzheimer's D	ementia							24a. Was a		24b. Were a	autopsy finding	s available
Re	The law	Completed									autops perform	ned?	death?	completion of s 2 \(\sime\) No	cause or
Vital		Bec	25. Was case referred to medical examiner?								(Check only on	e)			
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n	ing P	on:	27. Manner of Death 1 ☑Natural 5 ☐ Pending		of Injury oth, Day Year)	28b. Time of Injury	f 2	Bc. Injury Work	(?		28d. Describe ho	w injury	occurred		
Division	Attending r death. sctor: After by the fune	Icat	2 Accident investigat 3 Suicide 6 Could not	be an Bloc	e of Injury - At ho	ome farm str			/es 2□I	-	28f. Location (St	reet and	Number or F	Rural Route Ni	ım ber
<u>≥</u>	o ite	Certification:	4 ☐ Homicide determine	buile	ling, etc. (Specify	()	oot, raciory	, omos			City or Town				
	Hospitel or 24 hours afte Funerel Dir tely filled in		29a. Certifier 1 X Certifying	Physician: To th	e best of my know	wledge, deat	h occurred a	at the tim	e, date an	d place,	and due to the ca	ause(s) a	ınd manner a	as stated.	
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edical	(Check only 2 Medical Ex	aminer: On the and ma	basis of examinat nner stated.	tion and/or in	vestigation,	in my op	oinion, dea	th occurr	ed at the time, d	ate and p	place, and du	e to the cause	)(S)
	vithi To the	Σ	29b. Signature and title of certifier		-d -	_	29c	. License	number		2	9d. Date	signed (Mor	oth, Day, Year)	f
•			ratio	a DA	eller	my	D	_213	91			larch	11,	2005	
	8		30. Name and address of person wh		( ) -										
	Sta	to	Patricia D. Kel 31. Date filed (Month, Day, Year)	Logg, M	D. 12 Registrar's Signal	01 Sev ture	en Lo	cks	Road	Ro	ckville,	Mar	yland	20854	t
	Registr		MAR 142	005	Registrar's Signa	A Apple	ME								

			For 1 _ State		nd / Depa	artme	ent of Health and	•	_	oie. 0 5	10491
			* Registrar		Cei	unca	ate of Death	1.0.370	Reg. No.		
	Physici /Media		1. Decedent's Name (First, Middle, Last) Rudolph Lee Showe					2. Date of D Month March	Day 20	<sup>Үөөг</sup> 05	3. Time of Death
	Examir	ier	4a. Facility Name (If not institution, give s			4b. Ci	ty, Town, or Location of Deat	h	4c. County	of Deeth	
			Atlantic General				rlin			ceste	er
1540	Funeral Director		217–28–3969	7. Age (In yrs.		If Und Month	der 1 Year If Under 24 Hrs s Days Hours Min.		7, 1932		lece (Stete or Foreign htry) MD
19	pue *		Usuel Residence of Decedent  10a. State 10b. County	10c. Ci	ity, Town or Lo	cation					0d. Inside City Limits
O	death with the Maryland me 23a or 28a-f ehow LITUM be notified at	ō								1	1⊠Yes 2 No
1 %	28a-1	Director	MD Worcest	er sr	now Hil		Zip Code		10- 02:		
2 3	a or	급	6232 Timmons Rd.						10g. Citizen of V		ntry ?
0 =	eath	Funeral		12. Was Decedent Ever in U	15 12 1		21863	Specific Ves or N		.S.	an Indian,
		'n.	1 Never Married 2 Married	Armed Forces? 1 □XYes 2 □ No AY	1	f Yes, s	edent of Hispanic Origin? (S becify Cuban, Mexican, Puer	to Rican, etc.)	Blac	k, White,	etc.
5-0036	within 72 hours after death with the Marylan ane. then "netural", or tieme 23s or 28s-1 ehow ins Madical Exeminer mant be notified at	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	.my	1 🗌 Yes	25No Specify:		Specify	B]	lack
0	2 ho	ted	15. Decedent's Educ	cation	16a. Deced	dent's U	sual Occupation		16b. Kind of Bu	siness/inc	dustry
7 2	hin 7	ple	(Specify only highest grade	College (1-4or 5+)	(Give	kind of t DO NOT	vork done during most of wo use retired)	rking			•
202	giene grene er the	Completed	11th				Painter		Con	struc	ction
	be filed tal Hygie d other event, it	Be (	17. Father's Name (First, Middle, Last)				18. Mother's Nar	ne (First, Middle	, Maiden Sumam	a)	
/lai	should be nd Mental marked c	2	Theodore Showell				Louise	Johnson			
Rudo 28-3 Marylan	2 sho and is ma		19a. Informant's Name/Relationship (Ty)	oe, Print)	19b. Mailin	ng Addre	ss (Street and Number or Ru	ural Route Numb	er, City or Town,	State, Zip	Code)
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e II	o to T		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ R	20b. I	Place of Dispo	sition (A	ame of rother place)	Date	20c. Location -	Dity or To	wn, State
Showe II	Pages ment of i ant: If its ury or o		* 4 □ Donation 5 □ Other (Specify)	Mt.	Wesle	y UM	C Cem 3/17	/2005	Snow H	ill,	MD
Showe 11	permit. Pag Department Important: I eny injury o		21. Signatur - Funeral Ferrico License	e	22 T.	. Name	and Address of Facility N. Watson Fu	noral D	omo.		
٧/ <b>m</b>	20F = 9		100				West Rd., Sal			i	
	Physician		23a. Part Enter the disease, or compli- shock, or heart failure. List only on Immediate Cause (Final disease or condition	e cause on each line	th. Do not ent	er the m	ode of dying, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	/Medical Examiner lisician and period e prival-transit	Examiner	resulting in death)  Sequentially int conditions if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consec	,	Me	CANCER ICTIVE PR	euron	any D	SEX	<del>18</del> 6
8760,	hysicia	Cal									· · · · · · · · · · · · · · · · · · ·
P.O. Box 68	Hospital or Attending Physician: The law requires that the death certificate be executed 44 hours after death. 44 hours and effect death. Funeral Diffector. After this certificate has been signed by the attending physician and teneral prector, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	Bc. If yes, outcome of pregnation 1. Live birth 2. Feta 4. Pregnant at time of continuous purchases.	al death 3	Ectopic Other (	pregnancy specify)	- Trust land	23d. Date Mon	of deliver	ry Day Year
<u>s</u> ,	res that igned b be deta	ρ	Part II. Other significent conditions con	tributing to death but not res	sulting in the ur	nderlying	cause given in Part I.		obacco use contri		
orc	w requir been s	Completed						10	Yes 2 No	ı∐ Proba	ably 4 Unknown
e c	b taw has b	n p						24a. Was	osy pi	ere autop	sy findings available apletion of cause of
=	The tate ha	S						perfo 1 ☐ Yes		eath?	2 No
/ita	ysician: Th	Be	25. Was case referred to medical examiner?				26. Place of Dea	th Check on	one		
) t	Physi this c	70	10103 2010	ospital: 1 Inpatient 2 🗆		3 🗆 [		ome 5 Resi	dence 6 Othe	r (Specity)	)
2	ding Ph. h. After the	on:	27. Manner → Death 1 □ Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		28c. Injury at Work?	28d. Describe	how injury occurre	d	
sic	Attendi death. ctor: A y the fu	cat	2 Accident investigation 3 Suicide 6 Could not be	00- Di		М	1 Yes 2 No				
Division of Vital Records,	afor Attency after death Director: d in by the	Certification:	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, tarm, stre	et, facto	ry, office	City or To	Street and Numbe vn, State)	r or Rural	Route Number,
	e Hospital or Atten 24 hours after deatl • Funeral Director: letely filled in by the		29a. Certifier 1 Certifying Phys	ician: To the best of my kno er: On the basis of examina	owledge, death	occurre	d at the time, date and place in, in my opinion, death occu	, and due to the	cause(s) and man	ner as sta	ated.
	To the Hos within 24 h To the Fur completely	Medical	,	and manner stated.							
	S in S	-	29b. Signature and title of cartifier			2	DU62.53	2	29d. Date signed	(Month, D	Jey, Year)
	62		SUU CO				F. Auria Car	toned	3/12	/OS	
	The state of the s		30. Name and address of person who cor  10324 OLO OCEM  31. Date filed (Month, Day, Year)	npleted cause of death (Item 11 CIM BC	n 23a) (Type, I	SEX	un and	21811			
	Sta	te	31. Date filed (Month, Day, Year)	32. Redistrar's Signa	ature						
- 4	Registr		MAR 1 6 20	05 Marie	K. A	DEN					

			r icuse ry	tate of Maryland /			_	_	
			1 _ State	tate of waryland?	Certificate of			Reg. No. 2 0 0 5	101,92
			Registrar  1. Decedent's Name (First, Middle, Last)				2. Date of Dea		3. Time of Death
	Physici		Ruth Son	nderson			Month 03	09 2005	1320 M
	/Medic Examin		4a, Facility Name (If not institution, give stre		4b. City, Town	, or Location of Deati		-4c. County of Death	)
			Krince Georges Hose	rital Cente	- Cher	erly		Prince 6	evals
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last I	Months Day		8. Date of Birt (Month, Day 10-19-1	h 9. Birth	place (State or Foreign intry)
	Director		401-00-7710	59	Yrs.		10-19-1	1945   Kent	učky
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City, To	own or Location				10d. Inside City Limits
	Manyl faho	٥	Maryland P.G.	Lani	ham				1 X Yes 2 ☐ No
	the	rec	10e. Street and Number		10f. Zip Code	-		10g. Citizen of What Cou	intry?
	iurs after death with the Maryla al', or Itams 23a or 28a-1 ahov Examitter must be troutfled at	Funeral Director	9739 Good Luck Road	# 1	2	20706		U.S.A.	
	deati	ner		Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of If Yes, specify Co	Hispanic Origin? (S	pecify Yes or No-		
9	or Its	/Fu	1 Never Married 2 Married	1 Yes 2 No	1 ☐ Yes 2 🕱 N			Specify: Bla	
21215-0036		d by	3 ☐ Widowed 4 🗖 Divorced	Year or Dates:			1		
15-	"nat	lete	15. Decedent's Educati (Specify only highest grade co	ompleted)	Sa. Decedent's Usual Occ (Give kind of work don life. DO NOT use reti	upation le during most of wol red)	rking	16b. Kind of Business/Ir	ndustry
12	filed withi Hygiene. ther than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 5	Administrato		1	Federal Gov	ernment
	illed Hygi other ant, I	O	17. Father's Name (First, Middle, Last)			18. Mother's Nar		Maiden Sumame)	
lan	ould be Mental arked o	To Be	Charles Louis Garre	tt		Maxine	Elizabet	h Shauntee	
Maryland	2 should be filed withir and Mental Hygiene. Ia marked other than aumatic avant, Ire M		19a. Informant's Name/Relationship (Type,	Print) 1	9b Mailing Address (Stre	et and Number or Ru	ıral Route Numbe	er, City or Town, State, Zi	p Code)
			Timothy Sanderson/S	on (	anham, Mary	Tand, 207		ar, City or Town, State, Zi,	
Baltimore,	permit. Pages 1 and Department of Health Important: If itam 27 any injury or othar tr once.		20a. Method of Disposition 1 ☐ Burial 2 🗡 Cremation 3 ☐ Rem		of Disposition (Name of tery, crematory or other p	lace) 03/	/12/05	20c. Location - City or T	
Ë	permit. Pages Department of Important: If it any injury or o		`4 □Donation 5 □Other (Specify)	Rive	rdale Park (	, ,		Riverdale, M	laryland
3ali	permit. Departitimport		21. Signature of Funeral Service Licensee	100 10 21				Funeral Ho D.C. 20010	me, Inc.
	TU = 8 0		Manda C. D.	acun, cc 361					Approximate
. III	*		23a. Part1. Enter the disease, or complicat shock, or heart failure. List only one of Immediate Cause (Final	cause on each line.	o not egal the mode or o	ying, scorr as cardin	or respiratory ar	1631,	Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	Due to (or as a construence	1 Hem	outre	age.		
	Examiner			Due to (or as a consequence	3 00).	· / / / / / / / /	1		
		ē	Sequentially list conditions, b	Due to (or as a consequence	ce of):	a const			
	cuted id ansit	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events c						
o,	te be executed ysician and ie burial-transit	EX	resulting in death) Last	Due to (or as a consequence	ee of):	-			
3760,		Ilcai	d					-	
89 x	death certifica e attending ph d for use as th	Med	IF FEMALE:	16					
Вох	ath c attenc for us	ian	in the past 12 months?	If yes, outcome of pregnancy 1□Live birth 2□Fetal dea 4□Pregnant at time of death				23d. Date of deliv Month	ery Day Year
o.	he de	Physician/M	1 □ Yes 2 ☑ No 9 □ Unknown	9 Unknown	3 Citiel (specify)				
<u>α</u>	The law requires that the tte has been signed by thoage 2 should be detache		Part II. Other significent conditions contrib	outing to death but not resulting	g in the underlying cause	given in Part I.	23e. Did to	obacco use contribute to	the cause of death?
Records,	quires n sigr	Completed by	Drabelis	1			1 🗆 Y	res 2□No 3□Pro	bably 4 □Unknown
8	w require s been si should t	lete	H roserto	2-12-12-			24a. Was	an 24b. Were auto	opsy findings available
Re	The iz	Eo	Rose I	C 111	7-7		autop perfor	rmed? death?	ompletion of cause of 2□ No
Vital	(0	BeC	25. Was case referred to me cal	mun	) much	26. Place of Dea	ath (Check only o	7	20.110
f V	Phyalcian: this certific ral director,	ToE	examiner?	pital: 1 ☑Inpatient 2 ☐ ER/	Outpatient 3□ DOA	Other: 4 Nursing H	lome 5 Resid	ience 6 □Other (Speci	fy)
n of	ding Pt h. After th tuneral		27. Manner of Death  1 XNatural 5 ☐ Pending	28a. Date of Injury 28b (Month, Day Year)	o. Time of 28c. In			now injury occurred	
20	Attending r death. actor: After	cati	Accident investigation			☐ Yes 2 ☐ No			
Division	fter d fract n by	rtifi	3 Suicide 6 Could not be determined	<ol> <li>Place of Injury - At home, building, etc. (Specify)</li> </ol>	farm, street, factory, office	e	28f. Location (S City or Tow	Street and Number or Rur vn, State)	al Route Number,
	Hospital or 24 hours afte Funaral Dir tely filled in	Ce	CO. Cariffica (Contifuing Physical	and To the heat of multiplication	de destination	United the second release	, and does he has	(-)	
	Hos 24 ho Fun Fun	edical Certification:	29a. Certifier 1 Sertifying Physici (Check only one) Medical Exeminer	an: To the best of my knowled On the basis of examination and manner stated.	and/or investigation, in my	y opinion, death occu	rred at the time,	cause(s) and manner as s date and place, and due t	to the cause(s)
	To the Hospital or Attending Physician: within 24 hours after death. To the Funaral Director: After this certific completely filled in by the funeral director,	Me	29b. Signature and title of certifier		29c. Lice	nse number		29d. Date signed Month,	bay, Year)
	P S P O		1/1/1	10	0	307/6	2	3/9/0	0
Λ	(5)		30. Name and address of person who comp	leted cause of death (Item 23a	a) (Type, Print) 300]	Hospital	Drive	-/1/0	
L	(10)		James Catevenis, MD	)		verly, Mar		20785	
<b>'</b>	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature	hail .				
	Regist	rar	MAR 1 4 2005						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** WILLIAM ALPHONSO SCOTT, SR. MARCH 05, 4:35P M 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGES SUBACUTE CARE CENTER CLINTON Sex **XX**M 2□F If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign **Funeral** Days Months Hours Min. Yrs. Director 79 PENNŚYLVANIA 578 22 8789 JULY 01, 1925 Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show The Medical Examiner must be notified at XXYes 2 No MARYLAND PRINCE GEORGES UPPER MARLBORO Direct 10e. Street and Number 10g. Citizen of What Country? 23a 12426 RONALD BEALL ROAD 20774 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 22 No
If Yes, Give or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status hours after 1 Never Married XX Married Maryland 21215-0036 1 Yes XX No Specify Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Year or Dates: naturai 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) 12TH ADMINISTRATIVE ASSISTANT DEPARTMENT OF STATE marked other 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be faund Mental H LEWIS SCOTT ဂ VIRGINIA BUTLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 of Health item 27 I JANE E. SCOTT / WIFE 12426 RONALD BEALL RD. UPPER MARLBORO, MD 20774 Baltimore, important: if item 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Pages 1 20c. Location - City or Town, State 1 ☐ Burial XX Cremation 3 ☐ Removal from State permit. Page Department \* 4 ☐ Donation 5 ☐ Other (Specify) METROPOLITAN CREMATORY 03/10/2005 ALEXANDRIA, VA 21. Signature of Funeral Service Licenses MARSHALL'S FUNERAL HOME OF MARYLAND, INC. once lares 4308 SUITLAND ROAD SUITLAND, MD 20746 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CHRONIC OBSTRUCTIVE PULMONARY DISEASE resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Ener Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner certificate be executed burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical the as attending IF FEMALE USB 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy signed by the atte in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No XX Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an mea? 1 ☐ Yes 2□ No 1 TYes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Tes XXNo 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Attending XXNatural 5 Pending Injury death. 1 ☐ Yes 2 ☐ No investigation 2 Accident i or Attencatter death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide tilled hours a Funerai XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 24 the To the within 7 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) Muller ay mp D0052999 MARCH 14, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALI RAHIMIAN, M.D. 7501 SURRATTS ROAD #205 CLINTON, MD 20735 31. Date filed (Month, Day, Year) 2. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

		·	1 - For State Registrar AMEND#1	lOenerян?	State of 3/23/04.B	Mandan	-		of H	ealth a		•		00		10494
	0		Decedent's Name (First			With Law					1	2. Date of De	eath			3. Time of Death
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	/Medic Examin		4a. Facility Name (If not in			ber)	-	4b. City, T	own, or	Location of	of Death		4c.	County of		
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	Funeral		5. Social Security Number			. Age (In yrs.	last birthday)	If Under 1 Months	Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D	rth av. Year)		9. Birth	place (State or Foreign ntry)
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land	ld be filk ental Hy ked oth ic event	To Be	17. Father's Name (First, Hans Volt		ertsen					18. Mothe		o (First, Middle Lra Oh]		Surname	)	
Maryland 21215-0036	nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan ortinent of Health and Mental Hygiene. ortinent of Health and Mental Hygiene. ortinent: If item 27 is marked other than "neturel; or items 23a or 28a-1 show injuryloc wher treumetic event, it a Modical Examiner must be notified at injuryloc where the unstable modified at 9a.		19a. Informant's Name/R B. Eric Six						•			I Route Numb			tate, Zip	o Code)
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Baltimore,	permit. Pages 1 a Department of Hea Importent: If item any injury onthe		21. Signature of Furfal	Service Licens	Bons							seph Ga nue NW				Inc.
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		State of Maryland / Dep	artment of Health and Martificate of Death	lental Hygi	•	10495
		Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
Physic /Medi		Emily C. Van Sickle		March 10	, 2005 Year	8:40 P M
Exami		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	1
		Potomac Valley Nursing Home	Rockville		Montgomery	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day,	Year) 9. Birthpi	lace (State or Foreign try)
Director		3/9-60-0913 94 115	July Hall	10/23/1	910 Miss	issippi
and *		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L	ocation		11	0d. Inside City Limits
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To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physic properties of the funeral director, page 2 should be detached for use as the funeral director as the funeral director.	Me	29b. Signature and title of certifier	29c. License number	290	d. Date signed (Month, E	Day, Year)
15	1	I Amore Door and	D38262	Ma	rch 11, 200	)5
-1		30. Name and address of person who completed cause of death (Item 23a) (Type	Print)			
		A. Mendhiratta, MD, 2401 Research Blv	d. #330, Rockville	, Maryla	ind 20850	
Sta		31. Date filed (Month, Day, Year)  MAR 1 4 2005  33 Registrar's Signature	ule			
Regist	rar	MAR 14 2005 Bours D. My				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amend 20bper f.h., bg, 3/16/05 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month O3 5:30 p.m **Physician** 05 lhomas ION J AMES /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Risfield Nursing Alice Byrd Tawes
5. Social Security Number 6. Sex omerset If Under 24 Hrs. 8. Date of Birth Hours Min. 8. (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Months Days 1**X** M 2□ F 4ug. 20, 1926 218-16-7011 Yrs. Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" --- " any injury or other traumatic event." 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 Yes 2 No MD 30m erset **Funeral Director** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21817 U.S.A 108 Somers WUC 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 1 SZYes 2 □ No If Yes, Give Year or Dates: 1945 – 1946 1 Never Married 2 Married Specify: Black 1 Yes 2 No Specify: Be Completed by 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Sherwin William, Inc Elementary/Secondary (0-12) College (1-4or 5+) .aborer 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) \_ida 12 hillington Thomas **HRank** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MD 21838 Holland Crossing RD Mary L.T. Hundy - Niece Marion, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Hurlock, 3-18-5 4 ☐ Donation 5 ☐ Other (Specify) MD Veteran Comolin 22. Name and Address of Facility
Anthony E. Ward Funeral Home
30639 Hampdon An. Princess Anne, 21. Signature of Funeral Service Licensee MD 21853 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician ASCVD ' Immediate Cause (Final disease or condition resulting in death) /Medical **Examiner** Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed ng physician and as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) resulting in death) Last 23b. Did tobacco usa contributa to the causa of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yas 2 No 3 ☐ Probably 4 ☐ Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 ☐ No 1 Tes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) æ Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Medicai Certification: To 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours at To the Funeral D completely filled i 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 16 2005

DR. Vijay Karum bunathan, 201 Hall Highway, Crisfield, Md

Gleen & Spale

Registrar

State

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAR 1 6 2005

32. Registar's Signature

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	iyatcıalıyınıcılıcal	IF FEMALE: 23b. Was decedent pregr in the past 12 month 1   Yes 2   No 9   Unknown	nant	d	2 Fetal death	3 □Ectopic pregnanc 5 □ Other (specify) _	у		23d. Date of d Month	elivery Day Year
w requires that been signed be should be deta	led by ri	Part II, Other significant of	conditions co	ntributing to death b	out not resulting in	the underlying cause gr	ven in Part I.	I	cco use contribute	to the cause of death?
ician: The law requir certificate has been s' rector, page 2 should		25. Was case referred to	arte	ry dises	re				No death?	autopsy findings available completion of cause of
Attending Phyer death.  ector: After this by the funeral directions.	2	examiner? 1 Yes 2 No  27. Manner of Death 1 Natural 5 2 Accident	_ ⊢	28a. Date of Inju (Month, Da	y Year) 28b. 1	Time of 28c. Injury Wo	ner: 4 \( Nursing Horsing orsing Horsing Horsing Horsing Horsing Horsing Horsing Horsing	28d. Describe how	ce 6 Other (Sp	ecify) Rural Route Number,
To the Hospitel or within 24 hours afte To the Funerel Dir completely filled in I		(Check only 2 N	Medical Exami	sicien: To the best iner: On the basis o and manner st	f examination an	e, death occurred at the ti	opinion, death occur	red at the time, dat	e and place, and di	ue to the cause(s)
with To 1	2	29b. Signature and title of 30. Name and address of	person who co	ampleted cause of c	leath (Item 22a)	29c. Licens	30853	290	Date signed (Mon	nth, Day, Year)
H, I		31. Date filed (Month, Da)	0	Ivia Ji	our ,	Peninsu	la Region	nal Medi	real Cente	R
Registra		MAF	₹ 1 5 20	105 Kee	e st	Aparte				

		For State Registrar	State of	Marylan		artment of I		d Mental H	ygiene Reg. Ne	2005	101.99
		Decedent's Name (First, Middle	e, Last)				Dou.,	2. Date of D	eath		3. Time of Death
Physic		Sarah Richard	son Tabb					Month	h 2.	y Year 2005	11:02 P <sup>M</sup>
/Med Exami		4a. Facility Name (If not institution		er)		4b. City, Town,	or Location of D			. County of De	
		Montgomery Ge	neral Hospi	tal		01ney				Montgo	omerv
Funera		5. Social Security Number	6. Sex 7. 1 ☐ M 27 F	Age (In yrs. I		If Under 1 Year Months Days		Hrs. 8. Date of E Min. (Month, L	irth Day, Year)	9 B	irthplace (State or Foreign Country)
Director		577-24-7482 Usual Residence of Decedent	7.3.11.24	90	Yrs.			Jan 6	, 19	15 Vi	rginia
land ow		10a. State 10b. County		10c. City	y, Town or Lo	cation					10d. Inside City Limits
Mary Feb	ō	Marriand Man	t	C41	C-						1 □Yes 2 □No
h the	Director	Maryland Mon 10e. Street and Number	tgomery	211	ver S	10f. Zip Code			10g. Cit	tizen of What C	Country?
th wit	a.	14911 New Ham	pshire Ave				20905			USA	
r dea	Funerai	11. Marital Status	12. Was Decede Armed Force	ent Ever in U.	S. 13.	Was Decedent of I	Hispanic Origin an, Mexican, P	? (Specify Yes or Nuerto Rican, etc.)	io-	14. Race - Am Black, Wh	
s afte	by Fu	1 ☐ Never Married 2 ☐ Marri 3 🖫 Widowed 4 ☐ Divorced	If Yes, Give			1 ☐ Yes 2 📉 No	Specify:			Specify:	
hour	ed b	71	Year or Date	is:	16a Decer	dent's Usual Occur	nation		16b K	(ind of Busines	White
in 72 in 72	Completed	(Specify only higher	st grade completed)	F.)	(Give	kind of work done DO NOT use retire	during most of	working	100.10	and of business	Silidustry
d with	E O	Elementary/Secondary (0-12)	College (1-4	or 5+)	Hor	nemaker				Own Ho	me
othe other,	BeC	17. Father's Name (First, Middle,	Last)				18. Mother's	Name (First, Middle	e, Maiden		
uld by Wents	15	Percy Linwood	Richardson				Emma	a Rucker			
and I		19a. Informant's Name/Relations			19b. Mailir	ng Address (Street	and Number o	or Rural Route Num	ber, City o	or Town, State,	Zip Code)
and and man an		Jeffrey Tabb/	Grandson	201 0				dale, MD	_		
Ses 1		20a. Method of Disposition 1X Burial 2 ☐ Cremation	3 □Removal from Sta	ate 205. P	lace of Dispo emetery, crer	sition (Name of natory or other pla	сө)	Date	20c. L	ocation - City o	r Town, State
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or items 23a or 28a-1 show any lollury or other traumatic event, the Medical Exam as must be mainted at once.		`4 □Donation 5 □ Other (S		No				Mar 8, 2			y, MD
Dermi Departi Import		21. Signature of Funeral Service	Licensee					Hines-Rin			
		23a. Part1. Enter the disease, or	complications that cau	sed the death						er Spri	ng, MD 20904
1		shock, or heart failure. List Immediate Cause (Final	only one cause on eac	h line.	_			,			Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	a	as a consequ	g Cand	er					Years
Examiner		0		,							
P #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or	as a consequ	uence of):						
ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c		-0						
cate be executed oblysicion and the burial-transit	E	rosaking in additi/ cade	Due to (or	as a consequ	Jence or):						
physicate physicate	dicai		d								
certif certif	/We	IF FEMALE: 23b, Was decedent pregnant	23c. If yes, outcome							23d. Date of de	elivery
death death	iciar	in the past 12 months?	4☐Pregnan	ı 2 ☐ Feta! t at time of de		Ectopic pregnanc Other (specify) _	y 			Month	Day Year
by the	Physician/Me	9 Unknown	9□ Unknow	1							
w requires that the death certific been signed by the ettending f should be detached for use es	by P	Part II. Other significant condition	ons contributing to deat	h but not resu	ulting in the ur	nderlying cause giv	en in Part I.	23e. Did	tobacco u	use contribute t	to the cause of death?
een si		Hypertension				-		1	Yes 2	□ No 3 □X	robably 4 Unknown
law ras be	ple							24a. Wa	s an opsy	24b. Were a	utopsy findings available completion of cause of
The The page	Completed							per 1 ☐ Yes	ormed? 2 A No	death?	
eician: The law sertificete has b lirector, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:			0#		Death (Check only	one)		
Physe this earl dir	5	1 Yes 2 No 27. Manner of Death	28a. Date of I		ER/Outpatien 28b. Time of		4 🔲 Nursir	ng Home 5 Res			ecify)
ding After fune	tion	1 X Natural 5 ☐ Pendin	g (Month,	Day Year)	Injury	Wo	rk? Yes 2 □ No	200. 20001150	riow injui	y codamod	
Atten deat ctor:	fica	3 Suicide 6 Could i	not be 28e. Place of			et, factory, office					Bural Route Number,
e e lor	Certification;	4 Homicide	building,	etc. (Specify	")			City or 10	own, State	J)	
To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours effer death.  To the Funeral Director: After this certificate has been signed by the eltending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit		29a. Certifier 17 Certifyin (Check only 2 Medical	g Physician: To the be Examiner: On the basis	st of my know	wledge, death	occurred at the ti	me, date and p	lace, and due to the	cause(s)	and manner a	s stated.
the H iin 24 the Fi	Medical	one)	and manner	stated.	.on and/or int			Acuted at the time			
To Too	Σ	29b. Signature and title of certifie	100-			29c. Licens	1076	31		te signed (Mon	th, Day, Year)
12		Joga F	vonais	(HA)		リリ	LX /	<i>I</i> '		rch 1	U, WUS
		30. Name and address of person	711	death (Item	23a) (Type	ney Roger	WF) Le	onard, M.	D.		
9	tate	31. Date filed (Month, Day, Year)	0 17.7.7	strar's Signat	ture			-010			
Regis		MAR 14	2005	un l	K AD	SATE					

			1- For Amend Item 232, Ptg of Maryland, G842, 04/26 Registrar Certificate	96 Health and Mei	ntal Hygie	ene . N2 0 0 5	10500
			Decedent's Name (First, Middle, Last)		Date of Death	. NC (3 () ()	3. Time of Death
н	Physici				Month March	12,2005	7:50p M
	/Medic		Richard Eugene Wintermyer  4a. Facility Name (If not institution, give street and number)  4b. City, To	own, or Location of Death	ilai cii	4c. County of Death	7.50p
	Examir	er					
	Euparol		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1	kton   Year   If Under 24 Hrs.   8.	Date of Birth	Cecil 9. Birthp	lace (State or Foreign
	Funeral Director			Days Hours Min.	(Month, Day, Y	r 19,195	lace (State or Foreign try)  PA
			Usual Residence of Decedent	Je	prembe	1 19,195	ZPA
	yland		10a. State 10b. County 10c. City, Town or Location			1	0d. Inside City Limits
	the Marylar 28e-f show	tor	PA York Dover				1 ☐ Yes 2 No
	ith the	ire	10e. Street and Number 10f. Zip C	Code	10g	. Citizen of What Coun	itry?
	23a o 23a o ust b	οï	1595 Jug Road 1	7315		U.S.A.	
	ltems	Funeral Director	11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Deceden	ent of Hispanic Origin? (Specifi	v Yes or No-	14. Race - Americ	
9	after or Ite	F	1 Never Married 2 Married 1 TYes 2 T→No	fy Cuban, Mexican, Puèrto Ric	an, etc.)	Black, White,	
215-0036	72 hours affer death with the Maryland naturel', or Items 23a or 28e-f show draf Examble in util be inviffed at	l by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	No Specify:		Specify: Wh	ite
5-0	72 hours "naturel",	Completed	15. Decedent's Education 16a. Decedent's Usual (Specify only highest grade completed) (Give kind of work	Occupation	16	b. Kind of Business/Ind	dustry
21	within ene. than "	npi	Elementary/Secondary (0-12)   College (1-4or 5+)	done during most of working retired)			
21	filed withi Hygiene. other ther	Co		Technician			Salvage
nd	should be filed withir marked other than marked other than metic event, the M.	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (F	irst, Middle, Ma.	iden Sumame)	
yla	should be nd Mental marked c	ဥ	Marlin Wintermyer	Romain	e Kauf	fman	
Maryland	2 a a s			(Street and Number or Rural R	oute Number, C	ity or Town, State, Zip	Code)
-	and in Ealth m 27			. Pulaski H	-		
ore	jes 1 ar of Hea if Item or othe		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  20b. Place of Disposition (Name cemetery, crematory or oth	nor niacol -	h 14,	c. Location - City or To	wn, State
Ĕ	Pag nent ant: t		'4 □Donation 5 □Other (Specify)	uneral 2005	11 14,	New Cumb	perland, P
Baltimore	permit. Pag Department Importent: I eny injury o		21. Signature of Funeral Service Licensee Home, Lin Came and	Address of Facility		••	
m	90E 98			w G. Gee Fu			21021
	3 F. D.F.		23a. Part1. Enter the disease, or conflications that caused the death. Do not enter the mode shook, or heart failure. List only one cause on each line.	of dying, such as cardiac or re	spiratory arrest	ton, MD-	21921 Approximate Interval Between
	Physician		Immediate Cause (Final				Onset and Death
	/Medical		disease or condition resulting in death)  Due to (or as a consequence of):			_	ZWEEKS
н	Examiner		ASPIRATION	Aspiration	on Term	ninal	
		e	Sequentially list conditions, if any, regularly to immunitate Due to (or as a contequence or)	4			
20	uted a ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events				
1.	exector and and all-tra	Exa	resulting in death) Last  Due to (or as a consequence of):				
68760,	Physicien: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	ical					
89	ficate g phy is the	edic	V				
Вох	that the death certific ed by the attending p detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delive	rv
	atte atte	cia	In the past 12 months?  1 Ves 2 No  1 Live birth 2 Fetal death 3 Ectopic preg				Day Year
P.O.	the d y the	ıysi	9 Unknown	,,			
	res that the signed by t I be detach	P V	Part II. Other significant conditions contributing to death but not resulting in the underlying cau	use given in Part I.	23e. Did tobac	co use contribute to th	e cause of death?
ds	uires sign	d by	FUNGEMIA		1 🗆 Yes	2 □ No 3 □ Proba	ably 4 □Unknown
Ö	w require been si should b	ete	RESPIRATORY FAILURE		24a. Was an	24h Wore autor	osy findings available
Records,	ding Physicien: The lav h. After this certificate has funeral director, page 2	Completed			autopsy	prior to con death?	npletion of cause of
	r: Th		ANEMIA		1☐ Yes 2☐		21140
Vital	icier certif	Be	25. Was case referred to medical examiner?  Hospital:	26. Place of Death (C			
0	Phys this al du	2	TEMPAtient 2 ER/Outpatient 3 DOA	4 Nursing Home	5 Residence  Describe how	e 6 Other (Specify	)
, L		ion	T Cartaina S C I straig	c. Injury at Work? 1 ☐ Yes 2 ☐ No	. Describe now	injury occurred	
<u></u>	death. ctor; A the fu	cat	2 Accident		Leastine (Ctoo)	A and Mumber on Dura	Davida Africa ha a
Division	or Ai fiter ( Sirec in by	Certification:	4 Homicide  28e. Place of Injury - At home, farm, street, factory, obuilding, etc. (Specify)	Office 201.	City or Town, S	t and Number or Rurai itate)	House Warnber,
Ц	urs a		On Casting Physics Table 1				
	os on j	ica	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at a classification, in and manner stated.  20 Medical Examiner: On the basis of examination and/or investigation, in and manner stated.	t the time, date and place, and in my opinion, death occurred a	at the time, date	e(s) and manner as sta and place, and due to	ated. the cause(s)
	I 4 F 5		one) and manner stated.				
	the H	Med	29h Signature and title of certifier	License number	204	Date signed /Month /	Day Yearl
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: Afte completely filled in by the fune	Medicai	120.10	License number	1	Date signed (Month, L	
	To the H within 24 To the F complete	Med	Mayslund M.D Do	5051197	1	Date signed (Month, L ARCH 12, 2	
	To the H within 24 To the Complete	Med	30. Name and address for rson who completed cause of death (Item 23a) (Type, Print)	0051197	M,	ARCH 12, 2	05
)	$\wedge$		M.D DC  30. Name and address for rson who completed cause of death (Item 23a) (Type, Print)  MAYA GUPTA 110 W 91th STREET	0051197	M,	ARCH 12, 2	05
	Le the H within 24 within 24 to the F To the F Complete	ite	30. Name and address for rson who completed cause of death (Item 23a) (Type, Print)	0051197	M,	ARCH 12, 2	05